Developmental antecedents of psychopathy and sexual sadism amongst forensic mental health patients and prisoners: A psychoanalytic perspective

by

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To my parents, who do not understand much of this way of thinking, but are proud of my effort…

DECLARATION

The literature review, data collection and conclusions drawn are the result of my own work. I hereby declare that this thesis has not been submitted, either in the same or different form, to this or any other university for a degree.

Sections of this thesis have been presented in the following conference presentations and peer-review papers:

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ABSTRACT

Psychopathic and sadistic patients share several common characteristics, such as emotional detachment from the suffering of the others and proneness to instrumental modes of aggression and crime. Despite voluminous literature the aetiology of psychopathy and sadism remain largely unknown, whereas psychological treatments for psychopaths and sadists are marked by therapeutic pessimism, as these patients appear intransigent to any therapeutic intervention. The aim of this thesis is to explore the early environmental antecedents that contribute to the development of psychopathy and sexual sadism and investigate how they are related to violent, sexually violent and sadistic behaviour. Further, the study examines the association between psychopathy and sexual sadism. This research followed a mixed-method design involving paper-based questionnaires, behavioural scales and semi-structured interviews. The results indicate that psychopathy is significantly associated with sexual sadism. The two constructs, however, follow distinct developmental pathways. Both psychopathy and sexual sadism were significantly correlated with early aversive experiences. The findings of the study showed that psychopathic and sadistic patients experienced more traumatic experiences, such as neglect, abuse and parental humiliation than the non-psychopathic and non-sadistic ones. Overall, the study findings indicate that these early traumatic experiences contribute to the development of psychopathy and sexual sadism and are specifically associated with severe forms of aggression.

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LIST OF ABBREVIATIONS

APA	American Psychiatric Association
APD	Antisocial Personality Disoder
ASP	Assessment of Sadistic Personality
BAS	Behavioural Activation System
BIS	Behavioural Inhibition System
BPD	Borderline Personality Disorder
CI	Chief Investigator
DAB	Devaluation of Attachment Bonds
DSPD	Dangerous and Severe Personality Disorder programme
DSM-III	The Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
HRM	Historical Clinical Risk Management
ICD-10	International Classification of Mental and Behavioural Disorders, 10th edition
ICF	Informed Consent Form
LSRP	Levenson Self-Report Psychopathy Scale
MCMI III	Millon Clinical Multixial Inventory 3
MMPI II	Minnesota Multiphasic Personality Inventory 2
NHS	National Health System

NHS-REC	National Health Service Research Ethics Committee
NPD	Narcissistic Personality Disorder
NPI-16	Narcissistic Personality Inventory
NOMS	National Offender Management Service
PCL-R	Psychopathy Checklist Revised
PCL:SV	Psychopathy Checklist Screening Version
PI	Principal Investigator
PPI	Psychopathic Personality Inventory Revised
PTSD	Post-Traumatic Stress Disorder
RAAS	Revised Adult Attachment Scale
REC	Research Ethics Committee
RSQ	Relationship Scale Questionnaire
SESAS	Severe Adult Attachment Scale
SPSS	Statistical Package for the Social Sciences
SRP -II	Self-Report Psychopathy Scale 2
TEC	Traumatic Experience Checklist
UKCP	United Kingdom council for psychotherapy
VIM	Violence Inhibition Mechanism
VRAG	Violence Risk Appraisal Guide
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION: 'Finding the Hannibal behind the Cannibal'

1.1 Background and Context

Psychopathy and sexual sadism are amongst the most controversial and elusive concepts of our times. In the research literature, the two forensically related constructs have often been associated at a theoretical and a clinical level (Holt, Meloy, & Strack, 1999; Meloy, 1997b). Empirical studies have shown that psychopathy and sadism are linked to predatory violence (Meloy, 2002; Robertson & Knight, 2014); sexual offending and sexual homicides (Darjee, 2019; Gacono, Meloy, Sheppard, Speth, & Roske, 1995; Knight, 2010; Knight & Guay, 2006; Porter, Woodworth, Earle, Drugge, & Boer, 2003); emotional detachment from the suffering of others (Kernberg, 1980; Mokros, Osterheider, Hucker, & Nitschke, 2011; Porcerelli, Abramsky, Hibbard, & Kamoo, 2001); primitive object relations structure (Juni, 2009; Kernberg, 1975; Meloy, 2001); as well as non-sexual violence (Porter & Woodworth, 2006).

Very few studies, however, have sought to explore the covariation of the two constructs (Darjee, 2019; Holt et al., 1999; Mokros, Osterheider et al., 2011; Robertson & Knight, 2014). Although these studies have examined different manifestations of sadism, mainly in homogenous samples, they do offer further empirical validation to the theoretically proposed and clinically observed relationship between psychopathy and sadism. The aetiology and pathogenesis of the two constructs, however, remain largely unknown (Meloy, 2002), and psychological treatments for psychopathic and sadistic patients are marked by therapeutic pessimism, as these patients appear immune to any therapeutic intervention (Millon, Simonsen, & Birket-Smith, 1998).

Psychopathic and sadistic patients have been thus far considered to be difficult to treat, dangerous, and at very high risk of reoffending (Hare, 2003). Psychopathic patients are much more likely to be imprisoned for committing violent or sexually violent crimes than non-psychopathic patients (Kiehl & Hoffman, 2011). Furthermore, psychopaths are also much more likely to recidivate violently once released (Hare, 1996). Although the affective, interpersonal and behavioural traits that demarcate psychopathy are not necessarily linked with criminal behaviour, there are certain psychopathic characteristics (e.g. impulsivity) that increase the likelihood of engaging in criminal conduct and violent behaviour (Hart & Hare, 1997).

Psychopathy and sexual sadism are significant risk factors for violence and crime (Hare, 2006). Indeed, individuals with psychopathy and sadism are considered to be 'responsible for a disproportionate amount of serious repetitive crime and violence in our society' (Hare, 1992, p.289, as cited in Fine and Kennett, 2004). In the 2019/2020 the number of overall crime offences in the England and Wales reached approximately 5.8 million, whereas the incidence rate for homicide remains relatively low, with 11.4 homicides per million (Office for National Statistics, 2020). The number of sexual offences in the UK is equally low, including a total of 179 thousand sexual offences in 2019/ 2020 (Statista, 2020). Although the true prevalence rate of sexual sadism (and its variants, such as sadistic violence) is unknown, it is estimated that the 'true prevalence' is probably between 5% and 10 - 20% in sexual offenders (Marshall & Kenedy, 2003; Mokros et al., 2012; Marshall & Mashall, 2016).

Previous attempts to identify the aetiology of psychopathy and sexual sadism and their relation to violent and sexually violent behaviour have mainly focused on biological and genetic contributions (Daversa, 2010). Neuroanatomical, neurophysiological, as well as twin and adoption studies, suggest a genetic/biological basis of psychopathy and sadism, whereas

neuroimaging research has significantly contributed to our understanding of the psychopath's brain (Blair, 2013; Stein, 2000; Viding, Blair, Moffitt, & Plomin, 2005; Viding, McCrory, & Seara-Cardoso, 2014). The general consensus from biological research suggests that genetic factors account for approximately 40 to 60 percent of the development of psychopathic traits (Glenn & Raine, 2014). A plausible aetiology of a psychopath's brain abnormalities, however, still does not exist (Blair, 2001, 2003; Glenn & Raine, 2014).

It is hypothesised that the structural brain impairments in psychopathic patients are caused by abnormal neurodevelopment that results from both genetic and environmental factors (Gao et al., 2013). Nevertheless, the contribution of early environmental factors has received very little attention (Martens, 2001, 2011). Indeed, very few studies have explored the role of early environmental antecedents that impact upon adult personality development in psychopathic and sadistic patients (Brown, Dargis, Mattern, Tsonis, & Newman, 2015; Kirsch & Becker, 2007; Murphy & Vess, 2003).

Although psychopathic and sadistic traits are partly attributable to biogenic dispositions, environmental factors can shape and alter the direction of these dispositions (Millon, 2011). Research has shown that psychogenic influences can alter those traits and prompt violent behaviours (Raine, 2013; Glenn & Raine, 2014). To understand a personality disorder, however, why and how the pathology causes the behavioural deviance needs to be discovered (Blair et al. 2006). This understanding has to go beyond the simplistic and misleading nature–nurture dichotomy (Ribeiro da Silva, Rijo, & Salekin, 2015), as the biogenic and psychogenic factors often interrelate and interact in a complex way (Kernberg, 2016).

1.2 Overview of Study and Key Research Questions

The aim of this thesis is to understand the life course of psychopathy and sadism. To demystify psychopathy and sadism altogether would be, of course, much too ambitious a task. The primary focus of this thesis is to explore the environmental antecedents of psychopathy and sadism, particularly seeking to investigate how these antecedents are related to violent and sexually violent behaviour in sadistic and psychopathic participants.

Although the significance of psychopathy and sexual sadism as risk factors for violence and crime is well-demonstrated (e.g. Hare, 1992, 2006), psychopathy and sadism are not synonymous to violence or criminal behaviour. Indeed, there are many psychopaths and sadists who are not in conflict with the society and who have "successfully" managed to stay away from any manifestations of crime and/or antisocial behaviour. Those psychopaths and sadists present most of the core affective and interpersonal traits of the psychopathic disorder (e.g lack of empathy) but they are unlikely to be diagnosed as "psychopaths" or "sadists" are they hardly- present impulsive and antisocial traits (Stone, 2009). It is therefore necessary to distinguish between psychopathy or sadism "in mind" (i.e psychological structure), and psychopathy and sadism "in action", namely those individuals who have enacted their disordered states of mind.

This research was conducted predominantly using a forensic population, solely including offenders and forensic mental health patients who have enacted their psychopathic and sadistic state of mind to a point of committing a criminal offence. Consequently, any discussion on non-offender groups is not within the scope of this research, as one of the general aims of this study is to explore the potential association between psychopathy, sadism and violence. Indeed, participants for this study were violent and sexually violent forensic

mental health patients and prisoners who have transferred to secure psychiatric setting as part of their pathway plan and treatment.

Research on psychopathy suggests that the disorder is conceptualised as either homogenous (Neumann, Hare, & Newman, 2007), or heterogeneous construct (Lilienfeld & Fowler, 2006). Psychopathy refers to a constellation of traits and behaviours (Patrick, 2018), and it seems to represent a category and a continuum, but not a single diagnostic entity (Hare, 2003; Juni, 2010; Meloy, 2002). Some researchers proposed different types of psychopathy (Karpman, 1941; Lykken, 1995; Babiak & Hare, 2006; Juni, 2010), whereas others suggested that there are different levels of psychopathy, namely low, moderate and severe one (Meloy, 2001)

It important to consider that this is a study in a highly selected group of offenders and forensic mental health patients with psychopathy and sadism. The majority of the participants are men who detained under the English Mental Health Act in secure psychiatric settings, including a few offenders who were transferred to Frankland's Westgate unit PD service. The sample of this study is comprised by treatment seeking participants, who are probably different to either classic prison samples (e.g Hare, 2006; Cooke et al., 2005a) or community samples of psychopaths (e.g Cleckley, 1941; Lilienfeld & Widows, 2005).

In 2012, the majority of psychopathic and sadistic patients who were previously in the former 'Dangerous and Severe Personality Disorder' (DSPD) units were transferred to prisons where treatment programs have been developed for them. Those psychopathic and sadistic patients who have been transferred to medium security hospitals are arguably less psychopathic and sadistic comparing to offenders who are in high security prisons and they probably differ in terms of their diagnosis, attachment history and offence. A distinct characteristic of this particular group of psychopathic patients which differentiates them from

their fellow inmates in prison is their eagerness to undergo therapy. This is therefore a study on the environmental antecedents of psychopathy and sadism in a specialist sample of offenders and patients mainly within medium security psychiatric services; the limitation of this will be extensively discussed in the limitation section of the thesis.

Apropos of the environmental antecedents of psychopathy and sexual sadism, our current understanding is primarily based on single case studies with little empirical validation. There has been very minimal research thus far taking into consideration the contribution of early environmental influences on the development of psychopathic personality disorder and sexual sadism. Furthermore, an empirically validated developmental model that illustrates the life course of psychopathy and sexual sadism is virtually absent.

Nevertheless, such research could deepen our understanding of the behavioural consequences of psychopathy and sexual sadism, both generally and more particularly in forensic mental health patients. Furthermore, this could potentially inform psychotherapeutic interventions and treatments for psychopathic and sadistic patients. Based on this, the following questions were considered:

1) What are the early developmental antecedents and psychogenic factors that impact upon adult personality development in individuals who present with psychopathic and sadistic traits?
2) To what extent do they impact upon adult personality development in individuals who are diagnosed with psychopathy and sadism?
3) To what extent are these early developmental issues and trauma related to violent, sexually violent and sadistic behaviour?

The study also has two additional objectives:

1) To investigate the relationship between sexual sadism and psychopathy

2) To research whether sadism is a key trait within the construct of psychopathy.

In order to answer these questions, 15 months were spent collecting data in four secure hospitals and one former DSPD unit within a prison. Sixty-two patients across the above units consented to take part in the study. Fifty-nine patients completed the set of questionnaires, and eighteen out of them agreed to participate in the semi-structured interviews.

1.3 Overview of Thesis

This thesis is carried out from a psychoanalytic paradigm and particularly from an object relations heuristic. Object relations theory a branch of psychoanalytic thought that focusses on internalised relationships with an individual's significant others being crucial to personality development and psychopathology (Hinshelwood, 1991). As an offshoot of the psychoanalytic paradigm, object relations theory aims to explain how those very early relationships with the primary caregivers are internalised and manifest themselves in external behaviour (Fairbairn, 1954).

There is, of course, a perennial debate on whether psychoanalysis is still relevant in psychological science and practice today. Although psychoanalytic theory has recently been revised and updated by several psychoanalysts, psychoanalytic findings and ideas have gained very little empirical support (Fonagy, 2004). Despite being a controversial paradigm, psychoanalytic studies of personality have provided significant advances in the illustration of the constellation of traits characterising the field of personality disorders (Kernberg, 2016). By the same token, the unwillingness of psychoanalysis to support its findings with solid and persuasive empirical evidence contributed to its further isolation from the other empirical sciences.

It is beyond the scope of this thesis to argue on the scientific basis of psychoanalysis. We believe that a radical reduction of personality research studies to the presentation of a constellation of characterological traits across specific populations ignores the deeper psychological features of those traits and does not consider the complexity of the internal psychological structure of each individual, and thus "considers all traits as equivalent" (Kernberg, 2016, p. 146). The same criticism can be directed to the psychoanalytic researchers, who ignore the epidemiologically characterological traits and solely focus on the

intrapsychic psychological structures. Considering that the focus of this study is on the developmental antecedents of psychopathy and sexual sadism and their relation to violent and sexually violent behaviour, a psychoanalytic interpretation of the findings of the study, we believe, can give them a different meaning in the light of underlying psychological structures. We felt that object relations theory could provide the study with such explanations, and this is why a psychoalytic paradigm has been adopted throughout the study.

The thesis will start with a review of psychopathy literature (*Chapter 2*), with the aim to provide a comprehensive understanding of how the construct of psychopathy has been conceptualised and has evolved through time. Psychopathy has a long history in both research literature and the practice of forensic psychology and psychiatry. In everyday language, the psychopath is often portrayed as the ultimate Evil. Given this poorly defined understanding of the concept of psychopathy in everyday parlance, the first section of *Chapter 2* will focus on the conceptualisations and definitions of psychopathic personality, and briefly outline the historical development of the construct; its relationship with crime and antisocial behaviour, and a review of the gold-standard assessment tool for psychopathy, namely the Psychopathy Checklist Revised (PCL-R).

This will then be followed by a review of the early environmental antecedents of psychopathy and sadism, looking particularly at attachment abnormalities, early relational trauma, failures of internalisation and affective deficits in psychopathic and sadistic patients. Next, the general literature on aggression will be explored, presenting the differences between various types of aggression and providing a working definition of sadism.

Chapter 3 outlines the methodological approach to the study and particularly looks at the different assessment tools which are most applicable to the current sample of participants. A detailed description of each psychometric and the rationale for its selection will be

provided as well. The chapter further outlines the research questions, samples and data sources for the study, and describes the chosen methods of analysis for the data both for the quantitative, as well as the qualitative part of the study.

Chapters 4 and 5 illustrates the analysis of the quantitative and qualitative results of the study. The chapter starts with a detailed report and analysis of the quantitative results. It outlines the main findings both with regard to the relationship between psychopathy and sadism, as well as to the early developmental antecedents that predicted both constructs. This will then be followed by a presentation and analysis of the main themes that derived from the qualitative semi-structured interviews.

Chapter 6 explores the significance of the most important findings on the early environmental factors that impact upon adult personality development in psychopathic and sadistic forensic mental health patients. The mixed methods results will be discussed, and conclusions will be drawn with regard to the theoretical and clinical implications of these findings.

Chapter 7 is the concluding chapter of this thesis. This thesis concludes that early traumatic experiences in childhood and particularly parental neglect, abuse and humiliation significantly contribute to the development of psychopathic and sadistic traits and more specifically to severe forms of aggression, ranging from instrumental violence to sexually sadistic acts of cruelty.

It is hoped that the findings of the study will lead to a better understanding of the aetiology of psychopathy and sexual sadism; will inform the current literature regarding the psychopath's and sadist's mind; and will shed some light on how these patients experience their interpersonal relationships. The ultimate goal is to contribute to a further understanding

of psychopathy and sexual sadism, particularly in forensic mental health populations. Finally, our motivation comes from the need to go beyond the biogenic explanations of callousness; to look behind the psychopath's 'Mask of Sanity'(Cleckley, 1951) and find, as Gullhaugen and Nøttestad (2011) so nicely put it, the 'Hannibal behind the Cannibal'.

CHAPTER 2

LITERATURE REVIEW

2.1 THE PSYCHOPATHIC PERSONALITY: CONCEPTUALISATIONS AND DEFINITIONS

2.1.1 Overview of the Section

Psychopathy is a deviant developmental disorder characterised by severe emotional deficits (Blair, 2013; Hare & Neumann, 2008), an inordinate amount of instrumental aggression (Glenn & Raine, 2009; Meloy, 1997; Meloy, 2002; Meloy, 1995; Porter & Woodworth, 2006) and it has been associated with violence, crime and antisocial behaviour (Hare, 1991, 2003). Psychopaths are characterised by impulsivity, poor behavioural controls, self-aggrandisement and superficial charm (Kiehl, 2015). The most significant hallmark of psychopathy, however, is a lack of empathy accompanied by the absence of any remorse and guilt as psychopathic patients show very little concern for the suffering of others (Hare, 1996; Hare & Neumann, 2008).

Since psychopathy first appeared in psychiatric literature over 100 years ago, there appears to be a perennial debate on how psychopathy is best defined and a lack of clarity on how psychopathy is developed (Ogloff, 2006). Broadly speaking, psychopathy is conceptualised as either homogenous (Neumann, Hare, & Newman, 2007), or heterogeneous personality disorder (Lilienfeld & Fowler, 2006). Psychopathy represents a category and a

continuum, as it refers more appropriately to a constellation of traits (Patrick, 2018) and not to a single diagnostic entity (Hare, 2003; Juni, 2010; Meloy, 2002).

In recent decades, research interest in psychopathy has been considerably increased and psychopathic personality disorder has become one of the most popular research constructs in forensic psychology. Hare (1996) suggested that psychopathy is a 'clinical construct whose time has come' (p. 25). Throughout its history, psychopathy has journeyed beyond poorly understood definitions and historical misconceptions into an empirically measured construct. Our understanding of the psychopathic personality, however, remains relatively opaque. Indeed, there appears to be little consensus over the role of some psychopathic traits, and most significantly, the aetiology of the disorder (Salekin, 2002).

Central to this thesis is the argument that monolithic conceptualisations and poor definitions of psychopathy that fail to consider all the necessary components of the construct have contributed to the widely held belief that psychopathic patients are not treatable (Salekin, 2002). Considering that a potential treatment for psychopathy will derive from a definite understanding of what psychopathy is and what it is not (Polaschek & Daly, 2013), the first step in this thesis is to present an operationalisation of the psychopathic personality that delineates all the significant components of the disorder.

Given the confusion and heterogeneity of psychopathy, this section aims to provide an overview of the various conceptualisations of psychopathy, starting from the early historical forerunners to the most recent formulations of the disorder. To understand the psychopath, we need to understand their history; their enigmatic behaviour (Hare, 2003), their complex neurobiology (Blair, 2010) and their psychodynamics (Meloy, 2001). As Brittain (1970) rightly said a few decades ago: 'We cannot treat, except empirically, what we

do not understand and we cannot prevent, except fortuitously, what we do not comprehend' (p. 206).

2.1.2 Early Antecedents

Psychopathy was the first personality disorder to be introduced in clinical psychopathology (Millon et al., 1998). Historically, the first clinical description of the psychopathic personality is traced back to the beginning of the 19th century, and was proposed by the humanitarian psychiatrist Philippe Pinel (1806). Pinel (1806) described the condition he encountered as: 'No sensible change in functions of understanding; but perversion of the active faculties, marked by abstract and sanguinary fury, with a blind propensity to acts of violence' (Pinel, 1806/1988, p. 156)

Pinel named this condition *manie sans délire* (insanity without delirium) in order to describe a group of impulsive and self-destructive patients, who, did not, paradoxically, present any impairment in their reasoning abilities. In short, he referred to patients who presented psychological disturbance without thought-disorder, or, as he put it, mania without delusions (Horley, 2014). Pinel described those patients as excessively furious and emotionally deprived (Pinel, 1806).

Throughout the 19th century, the widely held belief was that madness was equated with impairments in reasoning abilities. Pinel, however, proposed a new type of madness; a type of madness related to emotional and affective deficits (Millon et al., 2004). Furthermore, Pinel emphasised the impulsive character of the psychopath; a finding that was clinically supported a century later by Cleckley (1941) and Hare (1991). Indeed, Pinel's concept of *manie sans délire* shares common ground with contemporary definitions of psychopathy, and it is often viewed as the beginning of our modern notion of psychopathy (Horley, 2014).

A few decades later, Prichard (1835), a British physician, espoused Pinel's syndrome of *manie sans délire*, and attempted to reformulate it. He initiated the term 'moral insanity' to refer to a group of patients who presented severe affective disturbances associated with

socially deranged behaviours. He understood psychopathy as a disorder that affects only the feelings and affections, or what he considered to be the moral powers of the mind (Horley, 2014). Pritchard, therefore, emphasised the affective basis of psychological disturbance versus an intellectual basis of the disorder. He described *moral insanity* as: '*…madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination*' (Prichard, 1835, p. 6).

The unfortunate choice of the word 'moral' added a moralistic approach to the study of psychopathy, changing the psychiatric focus from emotional deficiency to social depravity (Meloy, 2002; Millon et al., 1998). By the same token, Prichard attempted to coin a special term by employing one used differently in common parlance (Horley, 2014). Both Pinel's *manie sans délire* and Prichard's moral insanity, however, were very broad compared to contemporary conceptualisations of psychopathy as they could include most of today's personality disorders, except mental illness (Millon et al., 1998).

At the end of the 19th century, the German psychiatrist Koch (Koch, 1891/1893) launched the term *psychopathic inferiority* to shift the psychiatric focus from Pritchard's moral inferiority to the 'inferiority of brain constitution' (Millon et al., 2004, p. 162). Although Koch (1891/1893) spoke about the dynamics of criminal behaviour, his notion of psychopathy did not refer to anything offensive or antisocial. He was the first to introduce the term 'psychopathic' to argue that mental disturbance in these patients has an organic basis; however, the term was mistakenly used as a label for all mental irregularities for many decades (Koch, 1891).

At the beginning of the 20th century, Kraepelin (1904) introduced a more generic conceptualisation of psychopathy and proposed seven different types of the construct. Kraepelin's conceptualisation of psychopathy was an amalgam of biology and morality (Scott, 2014). He employed the term *psychopathic personalities* to refer to degenerative personality development (Millon et al., 1998). Although, he did not entirely differentiate himself from the rhetoric of moral inferiority perpetuated by his predecessors, Kraepelin's (1904) definition depicted the glib, impulsive, antisocial, charming and superficial character of the psychopath; traits which are included in the current definition of psychopathy as described by Robert Hare (2003).

Nevertheless, definitions of psychopathy such as Pinel's *manie sans délire*, Prichard's *moral insanity* and Koch's *psychopathic inferiority*, reduced the construct almost exclusively to antisocial and felonious behaviour. Although Prichard used the diagnostic label *moral* as referring to the affective aspects of the psychopathic personality, the concept was mistakenly misinterpreted as a synonym for antisocial (Willemsen & Verhaeghe, 2009). Throughout the 19th century, the psychiatric nomenclature had associated psychopathy with moral repugnancy, wickedness and evil; a stigma that is, unfortunately, still present in the media today.

2.1.3 Psychoanalytic Conceptualisations

From a psychoanalytic point of view, psychopaths are characterised by sadism and pathological narcissism (Gacono & Meloy, 1994) and they function at a borderline level of personality organisation (Kernberg, 1998; Myers, Gooch, & Meloy, 2005). These patients are unable to form affectional attachments towards others (Gacono & Meloy, 1991; Cartwright, 2002). They are individuals with defective and pathological object relations, who experience others as need-satisfying objects (part-objects) and they display primitive emotions such as projection, splitting, anxiety, savage aggression and primitive psychological defenses (Juni, 2010).

Freud understood the psychopath, but his reference to his personality was merely anecdotal. Like Pinel, he defined the psychopath in terms of destructiveness, as well as absence of love and empathy towards others. In his book *Dostoevsky and Parricide* (1928, as cited in Meloy & Shiva, 2007), Freud quotes: 'two traits are essential in a criminal: boundless egoism and a strong destructive urge. Common to both of these, a necessary condition for their expression is absence of love, lack of an emotional appreciation of (human) objects' (Meloy & Shiva, 2007, p. 1).

Freud, however, did not believe that the psychopath was a prototypical criminal. As he states in his book *Some Character Types Met within Psychoanalytic Work* (1916, as cited in Meloy, 2002, p. 8): 'Among adult criminals we must no doubt except those who commit crimes without any sense of guilt, who have either developed no moral inhibitions or who, in their conflict with society, consider themselves justified in their actions'. For the sake of clarity, it is important to mention here that, in contrast to the cotemporary conceptualisations of psychopathy, Freud did not believe that the psychopath cannot experience feelings of guilt and remorse. On the contrary, he interpreted his criminal and antisocial behaviour as defence

against unconscious feelings of guilt; he believed that a psychopath's antisocial behaviour was an unconscious effort to ameliorate intolerable feelings of guilt (Freud, 1916).

Three decades later, Cleckley, in his seminal monograph *The Mask of Sanity* (1941), defined the psychopath in a very similar way: a full of rage, affectionless individual who is constantly in conflict with society. Cleckley was profoundly influenced by psychoanalytic theory and most of his diagnostic criteria for psychopathy reflect psychodynamic implications (Meloy, 2002).

Freud's view of the psychopath influenced a number of other clinicians to investigate the psychopathic personality. Among the most notorious of them were Aichorn (1925, as cited in Millon et al., 1998), Alexander (1930, 1935) Karpman (1941,1947) and Levy (1951). Since the theory of object relations started to expand in Britain, eminent psychoanalysts, such as Reich (1933), Winnicott (1956) and Bowlby (1944) contributed to our understanding of the nature and dynamics of antisocial behaviour. More recently, Otto Kernberg (1975, 1980), Reid Meloy (2001, 2002, 2005) and Samuel Juni (2009, 2010), based on their research and clinical experience with psychopathic patients, expanded Freud's conceptualisation and formulated a psychodynamic model of the psychopathic mind.

Kernberg (1975, 1980, 1989) considered psychopathy as a severe and dangerous variant of narcissistic personality disorder (NPD). Kernberg's (1975) classification of psychopathy is incongruent with Alexander's (1935) and Karpman's view (1941); they considered the psychopath as a neurotic patient. For Kernberg (1975), the psychopath functions at a borderline level of personality organisation, and he is neither neurotic, as Alexander and Karpman suggested, nor a 'concealed psychotic' as Cleckley (1941) proposed. Drawing on Kernberg's work, Reid Meloy (2002) highlighted the psychopath's object relations and defence mechanisms and proposed a psychobiological model of psychopathy

based on object relations theory and recent neurobiological findings. More recently, Samuel Juni (2010) espoused Meloy's (2002) definition of psychopathy and proposed three distinct types of the disorder: superego deficit, sadism and hostile psychopathy.

2.1.3.1 Failures of Internalisation and Identity Diffusion

Failures of internalisation

Drawing from object relation theory and empirical research, psychopathy is conceptualised within the borderline level of personality organisation (Gacono et al., 1992; Kernberg, 1980; Meloy, 2002; Meloy et al., 1994). Central to the object relations model of psychopathology is the internalisation of early relationships with the primary caregivers. These internalised object relations form 'the groundwork of the evolving psychic structure, which subsequent experiences elaborate on' (Clarkin, Lenzenweger, Yeomans, Levy, & Kernberg, 2007).

Piaget (1926, 1928) first defined internalisation as the assimilation of someone's experience with others. He hypothesised the existence of biologically determined mental schemata, which are internal structures that organise an individual's experience with others. Freud (1937) also used the term 'internalisation' phylogenetically, referring to the internalisation of the death (aggressive) drive. Hartman (1939, as cited in Meloy, 2001, p. 9) described internalisation as 'the evolutionary and phylogenetic transfer of functional-regulatory mechanisms from the outside to inside'.

The concept of internalisation constitutes one of the most fundamental aspects of psychological functioning (Loewald, 1973). In normative development, the outcome of the process of internalisation is the construction of identity (Erikson, 1956; Kernberg, 2006; Kernberg, 2016) and the development of superego as a separate entity of personality

(Loewald, 2007).Two defining characteristics of the psychopathic personality, however, are identity diffusion and a lack of conscience. The second, will be elaborated on in the next section.

Identity diffusion

Psychopathic patients present a common underlying psychic structure which is central to their psychopathology, characterised by identity diffusion; pathology of internalised object relations; non-specific manifestations of ego weakness; predominance of primitive defensive operations; and a shift towards primary-process thinking (Kernberg, 1975).

Apropos of the pathology of internalised relationships, psychopathic patients do not present an integrated view of the self and lack an integrated view of significant others. These patients cannot form a concrete sense of self, based on the integration of both good and bad segments of their personality (Kernberg, 1968). They entirely lack, or present limited capacity to mentalise: they cannot recognise emotional states within themselves and others (Fonagy & Bateman, 2007).

This failure to integrate positive and negative aspects of oneself triggers powerful primitive defensive operations, such as splitting, denial, omnipotent control, primitive idealisation, and projective identification (Kernberg, 1975). Unintegrated experiences of different qualities are kept separately and projected onto others to protect the ideal self from the persecutory one (Corradi, 2013). In Kleinian terms (Klein, 1946), these patients present a pathological fixation to the paranoid-schizoid position.

Reid Meloy (2002) suggests that the capacity to internalise is totally absent in psychopathy. He posits that biological impairments parallel the psychopath's emotional failures. It is not clear, however, whether emotional abnormality is purely neurobiologically rooted (Blair, 2001; Blair et al., 2005); begin as a very early disruption of the organismic

requirements which subsequently activates the neurobiological affective systems (Kernberg, 2016; Meloy, 2001); or is a consequence of a psychopath's neglectful and abusive parental environment (De Ganck & Vanheule, 2015; Gullhaugen & Nøttestad, 2011a; West, 2016). Although research has shown that an abusive parental environment is central to the development of psychopathy (De Ganck & Vanheule, 2015; Marshall & Cooke, 1999; Gullhaugen & Nøttestad, 2011a) it also appears that the more severe the psychopathy is, the more neurobiologically rooted the cause of the disorder is (Glenn & Raine, 2014; Marshall & Cooke, 1999).

From an attachment theory perspective, as discussed, the first interaction with the primary attachment figure builds the framework for the establishment of future relationships with other people and constitutes the internal working models of behaviour. Fonagy and his colleagues have associated the development of severe borderline personality to attachment abnormalities in the first years of a child's life (Fonagy, 1999; Fonagy et al., 2003; Fonagy, 1991, 1993; Fonagy, Moran, & Target, 2017; Fonagy, Target, & Gergely, 2000).

Failures of internalisation begin developmentally with early deficiencies in the incorporative function. From the beginning of psychoanalytic thinking until today, identification and introjection have referred to the presence of object relations in the child's mind, not simply as precepts, but as structural entities of his personality. Incorporation, which reflects his desire to take in the object through his mouth, is a more primitive form of internalisation that appears in early infancy; the marker of incorporative deficits is the lack of trust in the environment that the mother provides (Schafer, 1968).

In psychopathy, the incorporative deficiencies are associated with subsequent failures in the 'identification systems' (Kernberg, 1975, 1980). Kernberg (1975) utilised the term 'identification systems' to include identifications, introjections and ego identity as part of the

process of internalisations of object relationships. The term identification refers to the modification of the self in order to resemble the object (Schaffer, 1968). Similar to incorporation, introjection is a fantasy of taking in the object in such a way that the latter can exist in the child's mind and he/she will be able to communicate with it (Schaffer, 1968); this is similar to the stage of object constancy that Mahler (1975) proposed.

2.1.3.2 Identification with the Aggressor

According to psychoanalytic theory, the only identification a psychopath can form is the archetypal identification with the aggressor (A. Freud, 1936; Ferenczi, 1933) or through the identification with the stranger self-object (Grotstein, 1982) or the predatory part-object (Meloy, 2001). From a psychodynamic and attachment viewpoint, a child may internalise a sadistic parental figure that leads to the development of an overwhelming atavistic fear of attack from others. Savage aggression, traumatic bonding and abuse from the primary caregivers are the psychodynamic roots of the identification with the aggressor (A. Freud, 1936; Ferenczi, 1933).

The psychoanalytic hypothesis of the identification with the aggressor suggests that the child develops a phantasy that helps them cope with the anticipation of the presence of the aggressive parental figure. The child inevitably internalises and identifies himself with the sadistic caregiver 'as a predator for whom he will eventually no longer be a prey, but will instead prey on others' (Meloy, 2001, p. 13). The psychopath internalises the stranger self-object but does not experience it as a separate entity; he experiences himself as, and identifies himself with, the stranger self-object. Although there are a couple of studies indicating the existence of a sadistic caregiver in psychopaths' early childhood, (Brody & Rosenfeld, 2002; Gacono & Meloy, 1994; Gacono et al., 1992); the evidence for this hypothesis is primarily coming from single case studies (e.g Coid, et al., 2013; Leach & Meloy, 1999). It is,

therefore, far from conclusive as more empirical studies are needed on different types of psychopathy in order to provide more specific conclusions with regards to nature and dynamics of psychopath's parental figure.

Recent neurobiological research supports the psychoanalytic idea of identification with the aggressor in psychopathy. According to these findings, it is not clear why psychopathic individuals present intact autonomic arousal to threat stimuli, but they show under-arousal to threat stimuli caused by visual imagery (Blair, 2001). This can be linked with the socialisation pathways in psychopathy. Indeed, research has demonstrated that socialisation in psychopaths is achieved through 'fear conditioning' (Blair, 2001, p. 729). However, this harsh, fearful and authoritarian socialisation process renders the development and internalisation of empathy in children.

A further neurobiological theory that supports the psychoanalytic hypothesis of the identification with the aggressor/identification with the stranger self-object is the disruption of the violence inhibition mechanism (VIM) in psychopathic patients (Blair, 2001). The VIM is a system that is present in both mammals and humans and when it is activated by intense anxiety, 'the sad and fearful responses of others, results in increased autonomic activity, attention and activation of the brain stem threat response system' (Blair, 2001, p. 730). Blair (2001, 2007) suggests that the unconditioned stimulus signal is disrupted in psychopathy, and as a result, the response to aversive unconditioned stimulus (sad or fearful facial expressions of others) is muted; this is a condition that has been associated with the dysfunction of the amygdala. As a result of this, psychopaths do not find the pain in others aversive, which may be an indication of an avoidant attachment style as well; this, however, will be discussed in the next chapter. Nevertheless, it appears that children who grew up with violent parents present an inclination to instrumental modes of violence (Raine & Yang, 2006).

2.1.4 Modern Conceptualisations of Psychopathy: Cleckley and the 'Mask of Sanity'

As was mentioned and briefly elaborated on in Section 2.1.2, the medical nomenclature during the 19th century had associated psychopathy with moral depravity and biological inferiority. At the beginning of the 20th century, Birnbaum (1926) introduced the term *sociopathic* and attempted to alter the psychiatric focus from the biogenic to the psychogenic nature of psychopathy, emphasising the early social and environmental factors related to the genesis of the disorder. The emergence of our modern understanding of psychopathy, however, is strongly associated with the work of Sir David Henderson. Henderson, (1939) considerably contributed to our understanding of the vicissitude of psychopathic personality. Henderson (1939) used the term "psychopathic states" and provided a comprehensive view of the psychopathic symptoms and clinical interventions. His notion of 'psychopathic states' include three types of those states, namely predominantly aggressive, predominantly passive/inadequate, and predominantly creative.

Henderson's (1939) aggressive psychopath refers to violent and/or sexually violent individuals who intent to kill or hurt the other or themselves. The aggressive psychopath lies and manipulates the others and his is prone to the regular use of psychotropic substances. The predominantly passive/inadequate psychopaths have a passive parasitic lifestyle drifting aimlessly through life, whereas the predominately creative psychopath represents an impulsive and emotionally unstable individual who is often erratic. In contrast with his precursors, and some contemporary researchers, Henderson maintained a therapeutic optimism with regards to the treatment of psychopathy, suggesting that clinicians should intensify their therapeutic efforts and strive to find new creative ways to work with the psychopathic patient.

Notwithstanding Henderson's (1939) important contributions, it was not until Hervey Cleckley introduced his seminal work *The Mask of Sanity* (1941) that the diagnostic label of 'moral inferiority', which derived from the aforementioned narrow conceptualisations of psychopathy, started to fade. What made Cleckley's contribution unique to the understanding of psychopathic personality was the shift from the misleading concept of moral insanity to a more comprehensive conceptualisation of psychopathy. What also differentiates Cleckley's psychopath from the older anachronistic conceptualisations of the 19th century was that he described a multidimensional and heterogeneous entity rather than a one-dimensional construct. This, however, remains an ongoing debate (Neumann, Hare, & Newman, 2007).

Today, our understanding of psychopathy is rooted in Cleckley's writings and clinical work with psychopathic patients (Bishopp & Hare, 2008; Horley, 2014). In *The Mask of Sanity* (1941), he proposed sixteen diagnostic criteria for psychopathy. In contrast to the established criteria for antisocial personality disorder postulated in the *Diagnostic and Statistical Manual of Mental Disorders* (which predominately focus on a spectrum of noticeable symptoms and behavioural patterns), Cleckley's conceptualisation of psychopathy was based on a synthesis of behavioural, interpersonal and affective characteristics.[1]

Cleckley argued that the biogenesis of psychopathy lies in childhood (De Ganck & Vanheule, 2015). In his conceptualisation, he focused on the interpersonal characteristics and emphasised the deep emotional deficits underlying the behavioural deviance in psychopathy (Cleckley, 1941). Cleckley (1941) described the psychopath as wearing a 'mask of sanity'; that reflects the capacity of the psychopathic patient to uphold a façade of 'normality',

[1] Some hallmark characteristics include: 'superficial charm; absence of nervousness and psychosis; unreliable; untruthful and insincere; lack of remorse and shame; inadequately motivated antisocial behavior; poor judgment and failure to learn from experience; pathologic egocentricity; general poverty in major affective reactions; fantastic and uninviting behavior' (Bishopp&Hare, 2008, p. 119).

behaving 'as if' they were able to experience positive feelings. He brought a psychoanalytic perspective to the understanding of psychopathy that included both the personality structure and behavioural traits of the disorder (Vitacco et al., 2005).

Cleckley (1941) suggested that the psychopath is someone whose behaviour is grossly disturbed and cannot cope with the demands of society. According to him, the foundations of psychopathy are built on affective deficiencies; antisocial behaviour; poor impulse control and low frustration tolerance; extreme self-preoccupation; and superficial charm. The psychopath is a pathologically egocentric and manipulative individual, who lacks the ability to learn from his mistakes and cannot experience feelings of remorse and guilt (Cleckley, 1941).

Although Cleckley's psychopath is an antisocial individual, who has little concern for the rights of other people, he is not a virulent criminal. For Cleckley, psychopathy and criminality cannot be equated (Horley, 2014). Interestingly, he theorised that the punishment that follows the crime does not mean anything for the psychopath who commits crimes even when the risk of getting caught is very high (Cleckley, 1941). The psychopath's antisocial and criminal actions are inadequately motivated and mostly related to material gain. Despite the absence of remorse and guilt, Cleckley's psychopath does not get involved in cruel or sexual sadistic crimes. On the contrary, he postulated that sexual psychopaths lack fundamental fantasy and their sexual life is 'impersonal, trivial and poorly integrated' (Willemsen, & Verhaeghe, 2009, p. 242).

In summary, Cleckley's revolutionary work was a landmark for our modern understanding of the clinical construct of psychopathy. He offered one of the most significant conceptualisations of psychopathy, which has influenced contemporary researchers and psychiatrists in North America (Hare & Neumann, 2006), including Robert Hare, who

developed the most widely used instrument to measure psychopathy, namely the Psychopathy Checklist Revised (PCL-R).

2.1.5 Robert Hare and the PCL-R

Following Cleckley's approach, Robert Hare operationalised psychopathy in the 1980s (Hare, 1970). Hare's work has been one of the most significant contributions to forensic research, and most importantly, to the assessment of psychopathy. His conceptualisation of psychopathy was a synthesis of interpersonal, affective and lifestyle characteristics (Hare, 1993). Hare based his development of what is often referred as the gold-standard research scale for the assessment of psychopathy, namely, the Psychopathy Checklist – Revised (PCL-R; Hare, 1991) on Cleckley's (1941) sixteen diagnostic criteria for psychopathy.

Hare proposed a broader and more clinically complex model of psychopathy than his precursors as his work has primarily been, with violent male and female offenders.. Therefore, it would be incorrect to consider Hare's contribution simply as an extension to Cleckley's work (Horley, 2014). In addition, Hare's PCL-R was not solely based on Cleckley's work; it was also influenced by the work of other researchers, such as McCord and McCord (1964), Karpman (1961), Craft (1965) and Buss (1966) (as cited in Lynam et al., 2011).

The Psychopathy Checklist Revised (PCL-R) is a reliable, well-validated and vigorous rating scale developed for the assessment of psychopathy in forensic settings[2] (Hare, 1991). The PCL-R is the most influential operationalisation of psychopathy and was

[2] Hare and his colleagues developed two further editions of the PCL-R to assess psychopathy in non-forensic and young populations respectively: the Psychopathy Checklist: Screening Version (PCL:SV; Forth, Brown, Hart, & Hare, 1996) and the Psychopathy Checklist: Youth Version (PCL:YV; Forth, Hart, & Hare, 1990).

originally created by Hare to measure psychopathy as a homogenous and unitary construct (Hare, 1980; Hare & Neumann, 2008; Shine & Hobson, 2008; Harpur et al., 1989).

2.1.6 Structural Properties of PCL-R

The PCL-R consists of 20 items which are classified into two factors: the interpersonal/affective[3] that reflects callous and unemotional traits, and the impulsive/antisocial factor[4], which is made up of nine impulsive and socially deviant behaviours (Hare, 1980, 1991, 1993, 2003). All the twenty items of the PCL-R can be scored as 0, 1 or 2 for each item. When the score is 'zero', the psychopathic feature is absent; 'two' signifies a present psychopathic feature, while 'one' means that the psychopathic feature somewhat applies or is present only in a limited sense (Hare, 1991, 2003). The checklist is administered by trained clinicians in parallel with semi-structured interviews and reviews of collateral information. According to the PCL-R rating scale, an individual who has a score equal to or greater than 30 is diagnosed with psychopathy (Hare, 1991; Hare, 2003).[5]

Hare (2003) has also proposed a four-facet model (or, the two-factor, four-facet model), whereas other cotemporary researchers have proposed a three- (Cooke & Michie, 2001), as well as a five-factor model (Costa & McCrae, 1992; Costa & Widiger, 2002, as cited in Bishopp & Hare, 2008); however, the traditional two-factor model is still widely used

[3] PCL- R includes the following interpersonal and affective features: Glibness/Superficial charm; Grandiose sense of self- worth; Pathological lying; Conning/Manipulative; Lack of remorse or guilt; Shallow affect; Callous/ Lack of empathy and Failure to accept responsibility (Bishopp & Hare, 2008, p. 122).
[4] PCL-R includes the following impulsive and socially deviant behaviours: Need for stimulation, Parasitic lifestyle; Poor behavioural controls; Early behavioural problems; Lack of realistic goals; Impulsivity; Irresponsibility; Juvenile delinquency; Revocation of conditional release (Bishopp & Hare, 2008, p. 122). The items 11(Promiscuous sexual behaviour), 17 (many short-term relationships) and 20 (criminal versatility) exist in both factors (Meloy, 2001, p. 199).
[5]There are different scales in the PCL-R which reflect the severity of psychopathy in patients: a mild psychopathy (10-19), a moderate (20-29) and a severe one, which is scored from 30 to 40 (Meloy, 2001).

(Bishopp & Hare, 2008). More recently, a triarchic model of psychopathy has also been proposed by Patrick, Fowles, and Krueger (2009).

Although the PCL-R (Hare, Hart, & Harpur, 1991) was based on Cleckley's (1941) description of psychopathic personality and reflects most of his diagnostic criteria for psychopathy, Hare completely abandoned Cleckley's neo-Freudian approach and avoided any psychodynamic theorising (Horley, 2014). Hare's formulation of psychopathy, as reflected in the PCL-R, is primarily a description of personality traits and socially deviant behaviours.

There appears to be some controversy about whether a two-, three- or four-factor model reflects more accurately and adequately the clinical characteristics of psychopathy. Cooke and Mitchie (2001) criticised Hare's (2003) four-factor model suggesting there is too much emphasis on antisocial behaviour. In contrast, Hare and his colleagues criticised the three-factor model for the exclusion of antisocial traits. This debate, however, is still ongoing (Hare & Neumann, 2005; Skeem & Cooke, 2010).

It is beyond of the scope of this section to provide an extensive comparison between the different models of the PCL-R. It is argued, however, that an in-depth understanding of the psychopathic personality goes beyond the description of any antisocial and impulsive behaviour (Juni, 2009). There are many psychopaths, often described as 'successful psychopaths' (Lykken, 1995; Ullrich, Farrington, & Coid, 2008) who are not antisocial and do not violate the social norms. Equally, there are many patients who have antisocial personality but are not psychopathic (Hare, 2003; Juni, 2010). The relationship of psychopathy with antisocial personality disorder will be further elaborated in the relevant section.

2.1.7 PCL-R Validity and Criticism

Abundant research indicates that PCL-R is the internationally accepted gold-standard instrument for the assessment of psychopathy due to the consistency, reliability and validity that it displays (Hare & Neumann, 2008). Evidence demonstrates that PCL-R items' reliability across six samples was found to be at 0.88; and internal consistency across 11 samples at 0.87 (Shine & Hobson, 1997). That indicates 'good to excellent' internal reliability, strongly suggestive of a scale measuring a single underlying trait. According to Hare (1991, as cited in Shine & Hobson, 1997) PCL-R has good content, concurrent, predictive validity as well as 'convergent and discriminative abilities' (Shine & Hobson, 1997, p. 548). PCL-R scores have also been associated with treatment responsiveness among forensic populations (Edens, 2001), whereas the administration of the instrument can facilitate the clinician's screening and treatment planning (Loving, 2002).

Although the PCL-R is the most validated and widely utilised psychometric instrument of psychopathy, it has been subjected to intense criticism (Bolt, Hare, & Neumann, 2007). This section will specifically refer to the criticism of the PCL-R as a psychological instrument per se, and not to Hare's concept of psychopathy, which will be discussed later in this chapter. As mentioned in Section 2.1.3, the PCL-R was designed to assess psychopathy among incarcerated offenders and forensic mental health populations. Consequently, the utility of the PCL-R in non-forensic settings has been considered limited (Lynam et al., 2011).

Further criticism is concerned with the homogeneity of psychopathy as it is illustrated in the PCL-R (Horley, 2014). Another criticism that has been put forward questions the validity of PCL-R across gender and culture (Cooke, 1997; Cooke, Hart, & Michie, 2004; Cooke, Michie, Hart, & Clark, 2005a, 2005b; Mokros, Neumann et al., 2011). The PCL-R

has also been criticised for overemphasising antisocial and criminal behaviour, which will be further elaborated in the following section.

2.1.8 Psychopathy and Antisocial behaviour

The association between psychopathy and antisocial behavior has long been a matter of dispute between researchers and clinicians. Throughout its development, the construct of psychopathy has frequently but mistakenly been subsumed by the diagnosis of antisocial personality disorder. Nevertheless, psychopathy is a much more clinically complex construct and cannot be simply reduced to antisocial and felonious behavior (Meloy, 2001). A clear distinction, therefore, between psychopathy and antisocial personality disorder (ASPD) is necessary (Hare, 2003).

In the DSM III and IV (American Psychiatric Association, 1980; American Psychiatric Association, 2000), the diagnosis of antisocial personality disorder primarily focused on social deviance and criminal behaviour without considering any underlying dynamics or personality traits. Research indicates that antisocial personality disorder is a considerably weak counterpart of psychopathy, which omits the central affective and interpersonal characteristics of the construct (Blackburn, 2007; Strickland, Drislane, Lucy, Krueger, & Patrick, 2013). Although the diagnosis of ASPD in DSM- 5 (*DSM-5*; APA, 2013) follows the one in DSM-IV, it shifts from the traditional diagnostic 'social deviant' framework to a more character-based approach that reflects some traits of psychopathy that were not captured in DSM IV (Strickland et al., 2013).

Both Cleckley (1941) and Hare (1970, 1980, 1991, 2003) depicted the impulsive and antisocial character of the psychopath. As aforementioned, Hare was criticised by Cooke and his colleagues (2010) in that he considered antisocial behavior and criminality as central components of psychopathy. Cooke et al. (2010) argued that antisocial behaviour is not a central trait of the psychopathic personality. They suggested that PCL-R's operationalisation of psychopathy has moved away from the early conceptualisations of psychopathy, which

predominately focused on the affective and interpersonal core of psychopathy (Skeem & Cooke, 2010).

Hare (1991), however, attempted to bridge this gap between antisocial personality disorder and psychopathy. He postulated that antisocial personality disorder is not synonymous with psychopathy (Hare & Neumann, 2008). Statistically speaking, three quarters of offenders in maximum security prisons meet the criteria for antisocial personality disorder, but only one third meets the criteria for psychopathy (Meloy, 1997, 2005; Hare 2003; Hare et al., 1991). It is estimated that only 11% of forensic psychiatric patients meet the criteria for psychopathy (Kirkman, 2008). The estimated prevalence of psychopathy in the general population in the UK is 0,6% (Coid et al., 2009), whereas psychopathic traits in the USA account for approximately 1% of the general population in the USA (Neumann & Hare, 2008)

From a psychoanalytic point of view, it is incorrect to consider antisocial behaviour as a disorder of personality (Juni, 2010). A patient who is characterologically and dynamically psychopathic is not necessarily antisocial and, of course, vice versa. The antisocial behaviour is not a diagnosis as it can be found in any individual whether they are severely disordered or not (Winnicott, 1956). Of course, there are early developmental dynamics that lead to antisocial behaviour, which will be presented in the following chapters. Additionally, Juni (2010) stated that antisocial behaviour is the result of poor impulse control and low social intelligence and should not be considered as character pathology. As the primary aim of this thesis is to provide a psychodynamic understanding of the developmental origins of psychopathy, the construct will schematically be analysed in terms of its interpersonal dynamic features.

2.1.9 Psychopathy and Criminality

Even though antisocial behaviour is one of the most obvious consequences of psychopathy, Hare argues that a psychopath's antisocial behaviour does not necessarily lead to offending, thus psychopathy is not synonymous with criminality (Hare, 1993). By the same token, an accumulating volume of research suggests that psychopathy is strongly associated with criminality (Forth & Mailloux, 2000; Gacono, Meloy, & Bridges, 2000; Meloy, 2002; Millon et al., 1998).The question that now arises is whether criminal behaviour is a distinct manifestation of psychopathy.

Pinel (1806) was the first psychiatrist who suggested that antisocial patients present an underlying form of mental disturbance. His contemporaries, as elaborated in Section 2.1.1, illustrated the psychopath as an evil, morally inferior and insane criminal; a picture that is promoted by the media even today. Nevertheless, it has been argued that criminal and antisocial behaviour are epiphenomena of the psychopathic disorder; they do not constitute either a trait or a diagnostic of psychopathy (Meloy, 2002; Kernberg, 1980; Juni, 2010).

On the other hand, PCL-R was constructed to measure psychopathy in forensic settings due to the high prevalence of the disorder in the forensic population (Hare & Neumann, 2010). The prevalence of psychopathic traits, as measured by the PCL-R in violent populations, may predict antisocial behaviour, as well as criminal versatility (Woodworth & Porter, 2002) and recidivism (Hare, 1996, 1998; 1999; Meloy, 2001).

Mounting evidence, however, indicates that psychopathic personality traits have been associated with various manifestations of criminal behaviour, ranging from partner aggression (Coid, Freestone, & Ullrich, 2012) and stalking (Storey, Hart, Meloy, & Reavis, 2009) to sexual sadism and sexual homicides (Mokros et al., 2011; Gacono et al., 1995;

Knight & Guay, 2006; Knight, 2010; Porter et al., 2003). In the USA, approximately 93% of male psychopaths are in prison (Kiehl & Hoffman, 2011; Morrell & Burton, 2014).

Psychopathy is a strong predictor of criminal recidivism (Cornell, 1996; Hare et al., 2000; Porter, Birt, & Boer, 2001; Porter et al., 2009): research has shown that one year after their release from prison, psychopaths are four to six times more likely to commit another crime compared to non-psychopaths; ten years after their release, seven out of 10 psychopaths tend to reoffend; a percentage that goes up to 90% twenty years after their release (Anderson & Kiehl, 2014). Furthermore, empirical studies in youths have indicated that psychopathic traits are predictors of future criminality and aggression in this population (Vitacco & Vincent, 2006).

Apropos of the aetiology of psychopaths' criminal behaviour, which will be discussed later, there appears to be some controversy within the research literature. Neurobiological models of psychopathy suggest that abnormalities in the limbic system predispose psychopaths to a more instrumental mode of violence (Anderson & Kiehl, 2014; Cornell, 1996; Meloy, 2006; Woodworth & Porter, 2002; Kiehl 2006; Blair, 2010). Further to the neurobiological predisposition to criminal behaviour, psychoanalytically oriented researchers have emphasised the contribution of early traumatic experiences to the genesis of psychopathic violence (Stone, 2009; Meloy, 2006; Juni, 2009). Seymour Halleck (1966, as cited in Meloy, 2001) linked the psychopath's criminal behaviour with underlying feelings of helplessness. Similar to Freud's notion of unconscious guilt, Halleck believed that crime is the psychopath's pathetic cry; it is his effort to protest against the world; to shout 'I don't really need you people, I don't really need anybody' (Halleck, 1966, as cited in Meloy, 2001, p. 166).

2.1.10 Narcissism and Psychopathy

Pathological narcissism is central to psychopathy (Gacono, Meloy, & Berg, 1992; Robert D. Hare, 1991; Kernberg, 1980; Hart & Hare, 1998; Meloy, 2001), as it 'is the functional and affective core of psychopathy' (Meloy, 2001, p. 11). Research has shown that psychopathic offenders are more narcissistic than non-psychopathic (Gacono, 1990). In the PCL-R, Factor 1 is also labeled as 'aggressive narcissism' and often described as 'selfish, callous, and remorseless use of others' (Harpur et al., 1988, as cited in Meloy, 2005, p. 80).

Narcissism and psychopathy appear to represent a continuum rather than categorical constructs (Penney, Moretti, & Da Silva, 2008). They have both been associated with aggression (Hare, 1991; Meloy, 2002; Bogaerts, Polak, Spreen, & Zwets, 2012); however, there appear to be different underlying mechanisms that trigger aggression in individuals with strong narcissistic and psychopathic traits (Jones & Paulhus, 2010). From a psychoanalytic poit of view, aggression can be considered a response to narcissistic injuries (Freud, 1915; Stolorow, 1975; Stolorow & Harrison, 1975; Kernberg, 1975). As Stolorow points out 'one finds the most violent aggression precisely in those individuals *who are the most narcissistically vulnerable*' (Stolorow, 1975, p. 445, italics added).

Contemporary studies have empirically assessed the relationship between narcissism and psychopathy. Most of the empirical findings on the relationship between psychopathy and narcissism derive from studies on the so-called 'Dark Triad' (Fossati et al., 2014). Paulhus and Williams's (2002) Dart Triad is a constellation of three distinct, but interrelated aversive personality traits: Machiavellianism, narcissism and psychopathy. Although these personalities have different origins, they do share several common features, including social aversion, emotional coldness, a socially malevolent character and aggression (Paulhus &

Williams, 2002). When assessed the relationship between psychopathy and narcissism, Paulhus and Williams (2002) found an overlap between the two constructs. Nevertheless, psychopathy and narcissism remain distinct diagnostic categories (Fossati et al., 2014; Paulhus & Williams, 2002), a finding that is supported by more recent studies (Rogoza & Cieciuch, 2018).

Another model of psychopathy is the triarchic conceptualization proposed by Patrick and his colleagues (Patrick et al., 2009). Like Paulhus and William's (2002) model, Patrick's (2009, 2010, 2013) proposition of the psychopathy structure includes three core phenotypic constructs: disinhibition, boldness, and meanness. The aim of the model was to reconcile and link different conceptions of psychopathy, as well as the alternative approaches for assessing the construct (Patrick et al., 2009).

Patrick's (2009) and Paulhus and William's (2002) models share many important similarities and differences. Patrick's (2009) major descriptive them of Meanness is similar to Paulhus' notion of Machiavellism (Rogoza & Cieciuch, 2018), and there is a theoretical overlap between and later and psychopathy (Jones & Paulhus, 2011). The two other components of Patrick's triarchic model, namely disinhibition and boldness, can also be compared to Paulhus and William's concepts of psychopathy and Machiavellism (Rogoza & Cieciuch, 2018). A major difference between the two models, however, is the presence of narcissism. Narcissism is a distinct trait of the Dark Triad, whereas the concept is not a distinct feature of psychopathy in Patrick's model (2009). By the same token, contemporary research on the Dark Triad suggests that the structure of the triad is rather dyadic instead of triadic, as it does not include narcissism (Rogoza & Cieciuch, 2018).

The cotemporary studies on the relationship between narcissism and psychopathy are insightful, but not without limitations. First, the diagnosis of psychopathy was based on self-

report measures despite psychopaths' notorious behaviour to lie, con and manipulate others (Cleckley, 1941; Hare, 1991). More significantly, however, these studies were conducted in non-clinical populations. This, under the absence of any neurobiological determinants for the development of narcissism (Millon et al., 2004) does not provide any information about the contribution and function of narcissism as a potential trigger of sadistic or psychopathic violence.

Kernberg (1975, 1984) has offered a unique contribution to our contemporary understanding of the function of pathological narcissism within the psychopathic personality. According to his view, the diagnosis of narcissistic personality disorder is based on four basic facets (Kernberg, 1975). The first diagnostic characteristic is *pathological self-love*, (excessive self-centeredness and self-reference, need for tribute and admiration from others, shallow emotional life, superiority, and grandiosity). Narcissistic patients also present *pathological object relations* (envy, primitive defence mechanisms, little or lack of empathy for others, need to control others). They experience feelings of emptiness and aloneness (*basic ego state*); and yet, they present a degree of *superego pathology* (incapacity to experience mourning, guilt and sadness).

For Kernberg (1975), as well as for Meloy (2002), psychopathy is a severe variant of narcissistic personality disorder, and psychopaths present similar constellations of traits as narcissists do. Patients diagnosed with NPD and psychopathy are both organised at a borderline level of personality (Kernberg, 1980; Meloy et al., 1994). However, what differentiates the narcissistic and psychopathic personalities from borderline personalities is the existence of an excessively pathological grandiose self.

Psychopaths and narcissists present a variation of the grandiose self-structure, which was first explained by Kohut and delineated later by Otto Kernberg (1976). Kernberg (1976)

theorised that the grandiose self-structure has three components: a *real self* (the actual specialness of the child); an *ideal self* (a fantasised image which compensates for all rage and envy) and an *ideal object* (a fantasised image of a completely loving and accepting parent). For Kernberg (1975) the grandiose self-structure in NPD and psychopathy cannot be conceptualised as a normal developmental pathway, as Kohut (1971) and other self-psychologists suggested, but as a severe manifestation of psychopathology.

The question that arises from the literature is whether the presence of pathological narcissism in psychopathy is sufficient to explain the extremes of the psychopath's behaviour. Another question is whether pathological narcissism can be considered a developmental hallway to psychopathy. It seems that there is not enough research to provide us with an explicit answer to the second question; however, a psychodynamic and developmental understanding of pathological narcissism will open the way for the understanding of psychopathy (Kernberg, 1980).

Although psychopathy shares common ground with narcissistic personality disorder in terms of the grandiose self-structure, object relations, and defence mechanisms, the two personality disorders are not identical. As Meloy (2001) postulates: 'pathological narcissism is a necessary core, but insufficient component, of psychopathy' (p. 191). What differentiates characterological psychopathy from narcissistic personality disorder is the behavioural devaluation of others. In contrast to narcissistically disordered patients, who shore up their grandiose self-structure by devaluing others in their phantasy, psychopaths must aggressively devalue others in real life, in order to maintain their grandiosity and to repair emotional wounds (Kernberg, 1975, 1976, 1980; Meloy, 2001). For the psychopath, others exist merely to gratify their sexual and aggressive impulses, as others are experienced as extensions of himself (Meloy, 2001).

This malignant mode of narcissistic repair can run the clinical spectrum from verbal insults to torture, rape and sadistic homicides (Meloy & Shiva, 2007). The aggressive devaluation of others is a clinical manifestation of the psychopath's omnipotent control and self-aggrandisement. Omnipotence, which is a manifestation of the grandiose self-structure as well, is a core intrapsychic factor in the constellation of psychopathy and has a two-fold aim. First, it functions as an intrapsychic defence and protects the psychopath from persecutory introjects (Meloy, 2005). Second, it is in the service of the defence mechanism of projective identification; the psychopath's self is split into a good and bad aspects; they project the bad one into others, who subsequently become helpless (Kernberg, 1975). Through the aggressive derogation of others, the psychopath protects his 'idealized identifications of the self as a Predator' (Meloy, 2001, p. 12); ameliorates past traumatic experiences (Juni, 2009b) and maintains his narcissistic equilibrium.

2.1.11 Subtypes of Psychopathy

The ambiguous relationship between psychopathy and criminal behaviour suggests separate types of psychopathy. Distinguishing the different types of psychopathy is crucial to our understanding of the causes of antisocial behaviour (McHoskey et al., 1998). The subtypes of psychopathy, as originally defined by Karpman in 1941, are *primary* and *secondary* psychopathy. Karpman (1941) followed Cleckley's (1941) diagnostic criteria and provided a broader view of psychopathy. Karpman (1941) theorised that both primary and secondary psychopaths are amoral, antisocial and aggressive; however, there are distinct aetiological and motivational differences between them.

He considered 'primary' or 'idiopathic' psychopaths as the 'true psychopaths'. Primary psychopaths are characterised by a genetic affective deficit, that renders their ability

to experience empathy, remorse and guilt, and also allows for a tendency towards callousness. Their behaviours are goal-directed and planful. By the same token, secondary or 'symptomatic' psychopaths are different to primary psychopaths in aetiology and emotional experience (Karpman, 1941). Secondary psychopaths are more neurotic, and their behaviour is characterised by elevated anxiety, impulsivity, depression and anger. While the aetiology of primary psychopathy is believed to be rooted in constitutional affective deficits, a secondary psychopath's emotional disturbance seems to be a result of early aversive life experiences (Karpman, 1941).

Lykken (1995) proposed several variants of the psychopathic personality. Following Karpman's (1941) tradition, his description of those variants was based on constitutional differences on the one hand, and parenting experiences on the other. Lykken proposed two broad variants of psychopathy: sociopathy, and psychopathy. He considered sociopathy to be a result of exposure to poor parenting and socialisation, whereas psychopaths do not necessarily have a history of aversive experiences (Lykken, 1995).

Babiak and Hare (2006) further suggested that there are different styles of psychopaths. They identified three main styles: the *classic* style; the *manipulative* style; and the macho style. The *classic* style psychopath presents a high number of traits and scores highest on the PCL-R, whereas the *manipulative* style psychopath presents higher on the interpersonal and affective facets but lower on the antisocial and lifestyle facet (Babiak & Hare, 2006). The *macho* style psychopath is considered to be the most aggressive one and usually they present higher scores on the affective, lifestyle and antisocial facets, but lower on the interpersonal (Babiak & Hare, 2006).

Drawing from psychoanalytic theory and clinical work, Samuel Juni (2009, 2010) distinguished three major types of psychopathy: *superego deficit*; *aggression driven*

psychopathy; and *sadistic psychopathy*. The *superego deficit* category refers to the so-called 'successful psychopaths' and also incorporates Cleckley's (1941) notion of 'semantic aphasia/dementia'. *Aggression driven psychopathy* characterises a psychopath who commits aggression for its own sake; aggression is an end itself and the ultimate goal is the destruction of the prey (Juni, 2010). In contrast, *the sadistic psychopath* derives pleasure and enjoyment from the hurt and humiliation of their victim; *sadistic psychopathy* reflects the destruction of the victim beyond death (Juni, 2010).

2.1.12 Treatment of psychopathic offenders and forensic mental health patients

Psychological treatments for psychopathic patients are rife with controversy (Hecht et al., 2018). The traditionally held belief had been that psychopathic patients are intransigent to any therapeutic intervention (Millon et al., 1998; Felthous, 2011), whereas other researchers suggested that not suitable treatment programmes appear to intensify the behavioural consequences of psychopathy (Harris & Rice, 2006; Reidy et al., 2013). This therapeutic pessimism goes back to the time of Hervey Cleckley (1941), who explicitly noted that psychopaths neither benefiting from treatment interventions nor able of forming an emotional bond conducive to effective therapy. In the Mask of Sanity (1941) Cleckley concluded that "we do not at present have any kind of psychotherapy that can be relied upon to change the psychopath fundamentally" (pp. 438–439). Indeed, most of the clinicians and researchers before 1990 shared Cleckley's view, suggesting that there was no evidence of a demonstrably effective treatment for psychopathy (Suedfeld & Landon, 1978; Hare, 1970).

Salekin (2002) argues that this generally negative disposition toward treating psychopathy stems from the confusion regarding the defining characteristics, as well as the lack of understanding of the aetiology of the disorder. There are, however, a few factors that fuel the pessimistic view that psychopaths are untreatable. Amongst the most significant of

them is the complex nature of their psychopathology (Lewis, 2018). Psychopathic individuals are a notoriously challenging group of patients to treat (Olver, 2016; Salekin et al., 2010); form weaker therapeutic attachments (DeSorcy et al., 2016); show less motivation and greater resistance to change (Onglof et al., 1990**;** Dolan & Coid, 1993**)** and its more likely to drop out of therapy before its completion (Olver et al., 2011).

Previous studies investigating the effect of a therapeutic treatment on psychopathic patients may have also contributed to the belief that psychopathy is untreatable (Salekin et al., 2010). Some of those studies, however, used retrospective data (Onglof et al., 1990; Rice et al., 1992); included patients who scored lower than the cut-off point of 30 on the PCL-R (Hughes et al., 1997); recruited homogenous groups of participants (Seto & Barbaree, 1999); and there was a lack of information with regards to the type of treatment that was offered (Hobson et al., 2000). Further research concluded that psychopaths obtain less therapeutic gain when compared to non-psychopaths (Hobson et al., 2000; Harris & Rice, 2006), and they are more resistant to therapeutic interventions (Morrissey et al., 2007).

Despite strong speculations against the efficacy of treatment for psychopaths, a growing body of research argues that the "tide may be turning" as there appear to be signs that therapeutic interventions for psychopathic individuals can be successful (Polaschek & Daly, 2013). In 2002, Salekin conducted a metanalysis of the psychopathy treatment literature. He reviewed 42 studies traversing 60 years of research on psychopathy treatment. Salekin (2002) found that the most effective treatment modalities were psychoanalytic and cognitive – behavioural, suggesting that approximately 60% of psychopathic patients benefited from treatment. Notwithstanding Salekin's hopeful conclusions, there was a number of methodological limitations and the scientific standards in these studies were low (Polaschek & Daly, 2013; Olver, 2016).

A decade later Salekin et al. (2010) reviewed a number of studies regarding the treatment of psychopathy since the earlier Salekin (2002) metanalysis. They found that there were treatment effects for psychopathic patients, however those effects were small. Both reviews, however, concluded that Therapeutic Communities (TCs) were the least successful therapeutic intervention for psychopathic individuals. TCs reported a success rate of 25%, which may be the outcome of the absence of therapist-patient interaction (DeSorcy et al., 2016). More contemporary studies, however, concluded that the presence of CU traits does not undermine treatment but creates difficulties in creating an alliance with the therapist (Oliver et al., 2013).

In the UK, the early approaches to treating psychopathy took place mainly within high security hospitals. Psychoanalytic group and individual approaches were most prevalent during this time for the treatment of any personality disorder in general, and psychopathy in particular **(**Cordess & Cox, 1998). Group psychoanalytic psychotherapy was one of the earliest therapeutic approaches to the treatment of patients with psychopathic traits. The Portman clinic in London has a tradition of offering group psychoanalytic psychotherapy to disturbed sadistic patients (Woods, 2014). The effectiveness of group psychoanalytic psychotherapy has also been supported by Foulkes (1960), one of the pioneers and founders of group analysis, who emphasised the importance of acting out in those patients with psychopathic traits.

The therapeutic community approach, which was originally developed by Jones (1956, as cited in Meloy & Yakeley, 2014) in England, has also played an important role in the treatment of psychopathic disorder (Lees et al., 2003). Henderson Hospital was an important therapeutic community for patients with sociopathy (Rapoport, 1960). The development of the Grendon Underwood programme (Snell, 1962), also contributed to the

treatment of psychopathic offenders. Indeed, a 10-year cohort study conducted by Robertson & Gunn (1987) showed that patients who participated in the Grendon Underwood therapeutic programme were more able to ask for psychiatric help when compared to the control group.

In the early 2000s, influenced by the murders of Michael Stone in 1996, the "Dangerous and Severe Personality Disorder (DSPD) programme was emerged. The DSPD pilot initiative programme was comprised by four high security pilot services for men (two in hospitals and two in prisons) and three medium security units. A few years later, however, the programme received intensive criticism due to its low therapeutic outcomes; the cost of it; as well as the lack of evidence in reducing the rick (Taylor, 2015).

Following the termination of the DSPD programme the Offender Personality Disorder Pathway Programme (OPDP; Joseph & Benefield, 2012) has developed in the UK. Considering the criticisms of the preceding DSPD programme, the aim of the OPDP was to provide more effective, as well as wider therapeutic interventions to personality disordered offenders (PDOs). The OPD pathway is co-commissioned by the NHS and the National Offender Management Service (NOMS), contributing to assessment, risk management, treatment and rehabilitation of PDOs in secure hospitals, prisons, as well as the community.

The OPD pathway difference from the preceding DSPD programme, is that it does not only focus on providing high – intensity therapeutic interventions on a selected group of high risk PDOs, but focusses on providing a structured living environment through care which facilitates the treatment process (Joseph & Benefield, 2012). Offenders are initially screened for the presence of a personality disorder, as well as the risk of committing a future serious offending and they subsequently allocated to a patient-specific pathway within the prison system where they undergo treatment.

To facilitate this, structured psychologically informed environments for PDOs developed in prisons, namely the 'Psychologically Informed Environments (PIPES; Bolger & Turner, 2013). Based on principles of psychodynamic theory and therapeutic community movement, PIPES were designed to provide psychosocial support to PDOs, not by providing treatment per se, but helping offenders to progress through their PD pathway and consolidate skills necessary for their rehabilitation. The development of Democratic Therapeutic Communities (DTCs) was another important service and part of the OPDP pathway, which also aimed to promote offenders' rehabilitation. More recent interventions for psychopathy include have also been developed (e.g. Chromis; Tew et al., 2012); those interventions, however, use aggression as an indication of treatment efficacy

Although the majority of the high-risk personality disordered offenders had moved out to prison settings where treatment programmes developed for them, the OPDP strategy allowed a tiny number patients to transfer to hospitals "when the offender's needs could not be met anywhere else" (Taylor, 2015). To be offered a place in medium security hospitals like that, the offenders need to demonstrate a wish and motivation to undergo therapy. Amongst those medium secure hospitals, the Millfield's Unit provides psychoanalytically informed and TC treatment to offenders, many of whom present high psychopathy traits (Taylor, 2015). Similar advantages in the treatment of offenders with psychopathy have also been made in Forensic Hospitals in the Netherlands, which adopt cognitive behavioural and schema therapy model (Bernstein et al., 2012; Chakhssi et al., 2010; Hildebrand & de Ruiter, 2012).

Treatability of a personality disorder is a confusing and elusive concept in psychiatry, whereas its assessment is a much more complex process (Adshead, 2001). The treatment of psychopathic offenders is an equally complex and controversial clinical matter (Olver, 2013). Since its very fist conceptualisation, psychopathy has been surrounded by therapeutic pessimism (Cleckley, 1941). The 'therapeutic nihilism' (Lion 1978, as cited in Meloy, 2001) is pervasive and has become engrained in clinical work with psychopathic patients, hampering potential developments in their treatment (Lewis, 2018). It is further hypothesised that this therapeutic pessimism is based on poor operationalisations of psychopathy and a lack of understanding of the aetiology of disorder (Salekin, 2002). Although, the successful treatment of the psychopath is currently remaining a fledging endeavour, there have been a number of tentatively encouraging indicators that it may be successful (Polaschek & Daly, 2013).

2.1.13 The Psychopathic Personality: Conceptualisations and Definitions Overview

Psychopathy was the first disorder of personality to be introduced in psychiatric literature. Throughout its history, the concept went through various historical misconceptions and clinical formulations. Despite voluminous research, the biogenesis of psychopathy remains enigmatic, whereas psychological treatments for psychopathic patients are rife with controversy. Considering that our understanding of the development of psychopathy remains relatively opaque, the aim of the following section is to present a review of the literature with regard to environmental antecedents of the disorder.

2.2 ENVIRONMENTAL ANTECEDENTS

2.2.1 Introduction

As stated, psychopathy is a severe and complex personality disorder whose aetiology is poorly understood. In recent decades, neuroscience has considerably contributed to our understanding of the psychopath's brain (Blair, 2013). Research evidence has shown that psychopaths present reduced functioning in brain areas associated with emotions (such as empathy, guilt and fear) (Blair, 2007; Blair & Mitchell, 2009; Glenn & Raine, 2014). Despite voluminous neuroanatomical and neuropsychological research, the causes of the neurological and brain abnormalities in the psychopathic personality remain unknown (Blair, 2001). Nevertheless, it is hypothesised that these biological differences result from both genetic and environmental factors (Gao et al., 2009; Glenn & Raine, 2009, 2014).

Today, research on psychopathy goes beyond the nature vs nurture dichotomy, acknowledging that genes and environment contribute equally to the biogenesis of the disorder (Ma et al., 2016; Glenn & Raine, 2014). Like many other personality disorders, psychopathy appears to be a result of an interplay of biological and environmental factors. The role of the environmental factors, however, has received very little attention. Much of the present research on psychopathy remains atheoretical and is primarily focused on the cognitive deficits of the disorder, devoid of all the underlying developmental factors (Daversa, 2010). Indeed, there is a scarcity of research on how the early developmental mechanisms impact upon the adult personality development of psychopathic and sadistic patients.

In the light of clinical and empirical evidence, the aim of this section is to review the literature with regard to the environmental antecedents of psychopathy, such as attachment

abnormalities, parental dysfunction, early relational trauma and negative care childhood experiences, and also to present developmental and aetiological theories of the disorder.

2.2.2 Attachment Theory

The theory of attachment is the crossroad where neurobiology meets clinical psychoanalysis; it bridges the gap between psychiatry and psychoanalytic theory (Fonagy, 2014). The genesis of attachment theory goes back to the work of John Bowlby (1944, 1969, 1973,1958, 1988,1980) and Mary Ainsworth (1982; Ainsworth, Bell, & Stayton, 1974; Ainsworth et al., 1978; Ainsworth, 1969). Since 1975, there has been considerable amount of research into attachment, as it has been proved to be a prominent and empirically anchored theoretical framework for the investigation of various forms of psychopathology (Langton, Murad, & Humbert, 2017).

Attachment is a biologically rooted species-specific behavioural system that aims to increase and maintain the proximity between the infant and the primary caregiver, who is usually the mother (Bowlby, 1951). Bowlby (1969) proposed four stages in the development of attachment; the first three occur during the first year of the infant's life, and the fourth one at about his third year. Attachment begins with simple objectless but goal-directed signalling and aversive behaviours, such as smiling, crying or vocalising, which seek to increase the proximity between the infant and the caretaker; to meet the child's physiological needs by securing food, warmth and protection (Bowlby, 1958); and also to promote a feeling of security which facilitates the child's exploration of their environment (Bowlby, 1969).

Bowlby (1969) named this first stage of attachment 'orientation and signals without discrimination of figure', whereas Ainsworth (1978) called it 'the initial pre-attachment phase'. At this stage, the infant's proximity seeking behaviours are not directed towards a specific person as the infant has not yet formed a bond with the mother. The infant can be

responsive to other humans as he or she does not yet have the capacity to discriminate between his mother and other adults (Bowlby, 1969).

Bowlby (1969) theorised that the foundations of secure attachment can only be understood in the spectrum of mother-infant interaction. During the first weeks of the infant's life, it is the mother who provides a secure environment for the infant and maintains the proximity seeking behaviour. Although Bowlby (1958) associated the development of insecure attachment with prolonged separation early in an infant's life, it was mainly Ainsworth's (1978) empirical work that stressed the importance of maternal sensitivity to the development of secure attachment. According to Ainsworth, harmonious and attuned responses to the infant's behavioural proclivities lead to the establishment of stable patterns of interaction between the mother and the infant.

Under favourable conditions, the aversive behaviours are minimised and the infant's proximity seeking behaviour gradually becomes more object-related, directed towards the primary attachment figure (Bowlby, 1969). This component initiates the second phase of attachment, namely 'orientation and signals directed towards one (or more) discriminating figure(s)' (Bowlby, 1969) or 'attachment – in-the-making' (Ainsworth, 1978). At this phase, the infant is able to differentiate one person from another and gradually begins to form a unique affectional bond with the attachment figure (Bowlby, 1969).

The third phase of attachment begins sometime between 6 and 9 months of age. Bowlby (1969) named it 'maintenance of proximity to a discriminated figure by locomotion and signals' and Ainsworth referred to it as 'the phase of clear-cut attachment' (Ainsworth et al., 1978). This phase is characterised by significant biological, behavioural and cognitive changes. Although the infant develops the ability to differentiate a few people during the

second phase of attachment, it is the third phase that the most experts consider as the real attachment phase (Cassidy & Shaver, 2008).

In this phase, the very first experiences with the primary attachment figure are organised into an attachment system which will later form a stable attachment style (Bowlby, 1958, 1969; Ainsworth, 1979). The attachment style is a relatively stable pattern that contains all the previous emotional interactions with the primary attachment figure and, therefore, creates a framework that determines how the child will relate to other people later in adulthood (Bowlby 1969; Ainsworth, 1989). These early interactions between the infant and the primary attachment figure are internalised by the infant and demarcate his attachment pattern later in adulthood (Fairbairn, 1952, 1946; Bowlby, 1969; Ainsworth, 1978). Bowlby (1969) referred to this first internalised interaction between the infant and the mother as *internal working modes (IWMs)*. Positive IWMs facilitate the development of the ability to 'mentalise' (i.e the ability to understand emotional states in self and others) or 'reflective-function' within interpersonal relationships (Fonagy et al., 2002)

Bowlby (1969) theorised that anger is the child's response to the separation from the mother as the need for her presence and emotional availability increases. However, research has shown that a mother's sensitivity to her child's need is critical and can significantly affect the child's capacity to reach a healthy equilibrium between the two extremes (Fonagy, Target, Gergely, Allen, & Bateman, 2003; Fonagy et al., 2003). According to Ainsworth (1980), consistent care and protection are considered to be the two primary functions of the Attachment relationship. Caregiver's ability to provide a 'secure base' facilitates the infant's development of self – efficacy and promotes security and autonomy (Cassidy & Shaver, 2008).

2.2.3 Attachment Insecurity

As elaborated in the previous section, attachment is defined as the inherent ability of human beings to form strong affectional bonds with significant others. The early relationships with the primary attachment figures are internalised, forming the internal working models (IWMs) which will provide the framework to approach relationships in adulthood. This section will discuss the consequences that an insecure attachment has on a child's psychological and emotional development.

Over the last few decades, attachment theory has been widely utilised by research scholars and clinicians to understand various forms of psychopathology. Bowlby believed that a better understanding of the normative course of attachment will lead to a better understanding of the attachment abnormalities (Cassidy & Shaver, 2008). He postulated that there are causal factors that can decrease the capacity for attachment and terminate the attachment behaviour (Bowlby, 1973). The most significant of these factors are the presence of a threatening stimulus; and the mother's behaviour, i.e. whether she withdraws from, or rejects the child.

Attachment insecurities refer to severe disturbances in the bond that exists between the infant and the primary attachment figure (Meloy, 2001). The disruptions of attachment have been labelled and measured. Ainsworth and her colleagues (1978) classified attachment behaviour into three categories: secure, insecure-avoidant and insecure-preoccupied, whereas Bartholomew (Bartholomew, 1990; Bartholomew & Horowitz, 1991) proposed four categories of adult attachment: secure, dismissing, preoccupied and fearful.

Severe disturbance in the attachment process is associated with partial deprivation (craving love/revenge accompanied by an excessive amount of guilt), or complete deprivation (antisocial behaviour, deceitfulness, stealing) (Bowlby, 1973). Bowlby (1969, 1973)

systematised a child's relation to the early maternal deprivation into three phases: protest, despair and detachment.

The onset of the *protest* phase is marked by an on-going threat of separation and characterised by intense distress, while the child is looking for the mother. Next, *despair*, which follows the protest phase, is characterised by the child's withdrawal/mourning and hostility towards other children. At this point, the child's anger is considered a response to separation (Bowlby, 1951). *Detachment* follows despair. The child has ostensibly recovered from despair; however, he presents abnormal behaviour, narcissistic withdrawal, absence of emotion and superficial sociability (Bowlby, 1969).

Ainsworth (1985) introduced two dimensions underlying insecure attachment: the anxious resistant attachment and the avoidant style of attachment. Anxious resistant attachment is the first disruption in the attachment bond. During this disruption pattern, the infant's behaviour is characterised by overwhelming distress, as he feels uncertain whether the primary attachment figure will be available to satisfy his needs. Anxious-avoidant infants appear to live pseudo-autonomously ignoring the presence of the mother when she returns (Ainsworth, 1985).

Bartholomew and Horowitz (1991) four-category model derived from Bowlby's theory of an individual's view of themselves and others and corresponds with Ainsworth and colleagues' (1978) two dimensions of insecure attachment. According to their model, individuals who present a secure attachment style are characterised by a positive view of themselves, as well as of the others. Securely attached individuals have high self-esteem and are able to regulate their feelings. On the other hand, individuals who have fearful attachment style have a negative view of themselves and a negative view of other people. Although they desire intimacy with others, they have an intense fear of rejection (Bartholomew & Horowitz,

1991). Preoccupied individuals have a negative view of themselves and a positive view of the others (Bartholomew & Horowitz, 1991). They are afraid of intimate relationships, seeking approval from others. Individuals who present a dismissing attachment style, have a positive view of self but a negative view of the others (Bartholomew & Horowitz, 1991).

Research has found that there appears to be an association between anxious-avoidant attachment pattern and traits such as impulsivity; aggression; and violent behaviour towards others (Bartholomew, 1990; Dutton, 2007; Gormley, 2005 Critchfield et al., 2008)). Further evidence suggests that when the mother is perceived as an aggressive figure, or when she is physically or emotionally sadistic, the child not only disavows the attachment, but he is led to the establishment of a sadomasochistic primary attachment (Meloy, 2002).

Other researchers have proposed additional patterns of insecure attachment. Main and Solomon (1990) observed a cluster of behaviours which could not be coded under the previous attachment classification systems and thus proposed the disorganised/disorientated attachment pattern. Infants who present a disorientated style of attachment appear disorganised when the parent returns after a short period of separation. In contrast to the anxious-avoidant style, where the infant ignores the presence of the caregiver, the infant's behaviour in the disorganised attachment style is marked by ambivalence: the infant approaches the caretaker and later on displays of avoidant behaviour (Main & Solomon, 1990). Such behaviours are usually observed in abused and traumatised children (Solomon & George, 1999).

2.2.4. Attachment Insecurity, violent offending and psychopathy

So far, it has been discussed that a successful, normative attachment promotes the development of self-efficacy, security and autonomy, whereas disruptions of the attachment bond appear to be, in some cases, a risk factor for the development of psychopathology,

anxiety and multiple forms of aggressive behaviour. The aim of this section is to review the research literature with regards to the relationship between attachment insecurity, violent offending and psychopathy.

Violent offending is multi-factorial, and insecure attachment in isolation is insufficient to provide an adequate model of offending and violent behaviour (Ward et al., 1996). Nevertheless, insecurities of attachment have shown to contribute to violent and sexually violent offending (e.g. Barbaro et al., 2018; Ross & Pfafflin, 2007). By the same token, attachment insecurity is common in the general population (approximately 40% of non-offending population could be classified as insecure), but is quite rare in offending populations (van Ijzendoorn, 1995). Insecure attachment, therefore, could only be considered as one single factor that can contribute to violent offending (Ward et al., 1996).

As discussed in the preceding section, the early lives of personality disordered patients with sadistic and psychopathic traits are marked by neglect, and various traumatic experiences, including emotional, physical and psychological abuse. The early aversive childhood experiences of the violent psychopathic patients, their interpersonal and emotional difficulties, as well as the current challenges with regards to their treatment, strongly indicate the relevance of attachment theory for this population (McGauley & Rubitel, 2006).

Over the last few decades, there has been a significant number of theories associating the development of psychopathy to disruptions in attachment bond during early childhood (Bowlby, 1951; McCord & McCord, 1964; Kernberg, 1980; Meloy, 2002, 2005; Juni, 2010). Indeed, one of the most significant characteristics of psychopaths is the absence of any affectional attachments to other human beings (Gacono & Meloy, 1991). Research has shown that psychopaths present severe affective deficits and absence of any relational capacity to

bond with other people (Blair, 2005; Blair & Mitchell, 2009; Cleckley, 1941; Hare, 2003; Blair, Mitchell, & Blair, 2005).

As early as 1944, Bowlby was probably the first who identified the relationship between psychopathy and attachment disruption in early childhood. In his seminal paper 'Forty-Four Juvenile Thieves' (1944), he studied the psychopathological effects of early maternal deprivation in a sample of 44 juvenile thieves. He found that children who suffered maternal deprivation tend to present severe deficiencies in the affective faculty, being transformed into 'affectionless characters'. Bowlby (1944) theorised that prolonged separation from the mother and constant maternal rejection lead to the development of what he described as 'affectionless psychopathy'. Bowlby's affectionless psychopath is profoundly detached from the others; displays no emotion; and his behaviour is characterised by apathy and self-absorption (Bowlby, 1944).

Bowlby (1944) therefore postulated that the antisocial behaviour in the group of patients he worked with, has its roots in disturbances of the attachment bond caused my prolonged and early separation from the mother. A few decades later, Farrington (1995) supported Bowlby's (1944) view that separation from the primary caregiver, along with other negative care childhood experiences, (e.g harsh parenting) is a predictor of subsequent offending in 8-year-olds. Notwithstanding that there appears to be some continuity between early delinquency and later offending, there is also discontinuity as the majority of children who present an insecure attachment do not become offenders, whereas many adult offenders have no history of juvenile delinquency (McGauley & Rubitel, 2006).

Insecurity of attachment, however, seems to represent a vulnerability for the development of violent and antisocial behaviour (Hoeve et al., 2012; Ribeiro da Silva, Rijo, & Salekin, 2015; Salekin & Lochman, 2008; Savage, 2014). Research indicates that

individuals who have experienced anxious-avoidant attachments may present traits such as impulsivity; aggression; and violent behaviour towards others (Bartholomew, 1990; Dutton, 2007; Gormley, 2005). Anxious and insecure attachments predicted ASPD, conduct disorder; borderline personality disorder (Bakermans-Kranenburg & Van IJzendoorn 2009; Fonagy et al., 2000); and sexually coercive behaviour (Marshall & Barbaree, 1990; Barbaro et al., 2018; Langton et al., 2017).

Since 1944, there has been a number studies researching the contribution of attachment in violent offenders, many of whom probably present psychopathic traits. The Ward et al. (1996) study was probably the first one that examined the relationship between attachment and violent offending in adult offenders. Their study was comprised by four subgroups, namely violent offenders, rapists, child molesters and a control group of non-violent offenders. Attachment orientations was measured through the administration of the Relationship Scale Questionnaire (RSQ). The authors found that the vast majority of the offenders was insecurely attached, and there were no considerable variations between them (child molesters, however, were found to be more preoccupied whereas violent offenders were more dismissive).

The scarcity of secure attachments amongst violent offenders was confirmed a year later by van IJzendoorn's study (1997). His sample consisted of 40 violent and sexually violent male patients admitted to two Dutch secure forensic mental health hospitals. It was found that approximately 55% van IJzendoorn's sample had a diagnosis of a personality disorder, with borderline and antisocial personality disorders to be most prevalent (van IJzendoorn's et al., 1997). Through the means of the Adult Attachment Interview (AAI) results of the study showed that only 5% of the participants were classified as secure, whereas

there was an over representation of dismissing (Ds) and cannot classify (CC) attachment patterns.

A similar study conducted by Frodi et al. (2001) examined the mental representations of the early attachment relationships in 14 incarcerated violent psychopaths who were housed in prisons and secure forensic psychiatric settings in Sweden. They found that violent psychopathic offenders experienced physical abuse more often compared to non-psychopathic inmates, proposing an association between childhood maltreatment and higher psychopathic scores. Frodi et al. (2001) did not find any association between the AAI classifications and the degree of psychopathy, as the classifications were nearly identical between participants who scored high and low on the PCL:SV.

When distributed the AAI using the three main classifications, Frodi et al. (2001) found that 64% (n=9) of the participants presented dismissing attachment pattern (D), whereas seven percent of the participants (n=1) displayed autonomous attachment style (F). Four participants in the study (29%) presented preoccupied attachment orientation (E) and only one secure patient was reported, who, however, suffered severe trauma in his early childhood. As Frodi et al. (2001) point out: "close to two-thirds of our participants were characterized by an inability to see the value of attachment figures and attachment –related experiences" (p. 275).

As in van IJzendoorn's (1997) and Frodi's (2001) study, Levinson & Fonagy (2004) used the AAI to investigate the contribution of attachment amongst prisoners with a diagnosis of a mental disorder. Levindson & Fonagy's (2004) sample was comprised by three groups: prisoners with mental disorders; psychiatric controls (non-violent personality disordered patients who had a similar diagnosis to prisoners); and normal controls. Similar to the

aforementioned studies, the researchers found that offenders had reported a higher rate of insecure attachments, especially in the dismissing category, when compared to both normal and psychiatric controls (Levinson & Fonagy, 2004). Nevertheless, both Frodi et al. (2001) and Levinson & Fonagi's study (2004) used small samples and the group of violent offenders in both studies was mixed with regards to the offence type.

Although the aforementioned studies appear to support the existence of an association between attachment insecurity and offending behaviour, other studies argued that attachment insecurity cannot be considered as a central determinant in offending behaviour. Using the Simpson Attachment Scale (Simpson, 1990, as cited in Goldstein & Higgins-D'Alessandro, 2001), Goldstein & Higgins-D'Alessandro (2001) examined the attachment orientations in violent and non-violent offenders. They reported no differences in the attachment patterns between violent and non-violent offenders, and the control group (non-offenders). No statistically significant differences in attachment styles were observed in Nussbaum et al. (2002) study. In a sample of 184 participants, comprised by violent, sexually violent, mixed, and non-violent groups, they observed no differences in attachment in self-reported attachment orientations.

The assumption that some manifestations of criminality arise in the context of insecure attachment was further challenged by Baker and Beech (2004). The authors investigated the attachment orientations amongst violent and sexually violent offending groups through self-report measures (RSQ). The authors reported similar results to the Nussbaum et al. (2002) study, finding no statistically significant differences in self-reported attachment styles between the offending groups and the normal controls. In addition, Bake and Beech (2004) found high levels of insecurity in non-offending populations, questioning whether insecure attachments could be considered a risk factor of criminal behaviour, a view

proposed by other researchers (i.e. IJzendoorn's 1997; Frodi et al., 2001). The same conclusions were drawn by the Stripe's et al. (2006) who found that the majority of their sample was insecurely attached and that there were no significant differences in secure attachments when measured by the AAI, between the offending and control groups.

Notwithstanding the questions raised by Bake and Beech (2004), more contemporary research suggested that there appears to be an association between insecure attachment and violent offending (Ross & Pfafflin, 2007**;** Chiffriller and Hennessy, 2010; Ogilvie et al., 2014; Schimmenti et al., 2014**)**. Through a meta- analysis of 30 studies including 2798 participants, Ogilvie et al. (2014) examined the relationship between offending and attachment security. The results indicated that attachment insecurity was positively associated with all types of offending, suggesting that it may be a violence risk factor. Indeed, offending groups were more insecure than non-offending controls (Ogilvie et al., 2014). Within the offending group, the authors concluded that violent offenders were more insecure than their non-violent inmates, whereas mixed results reported with regards to attachment insecurity between violent and sexually violent participants.

Furthermore, there appears to be a positive correlation between dismissing attachments and disorders related to psychopathy, such as conduct disorder and antisocial personality disorder (Allen, Hauser, & Borman-Spurrell, 1996; Bakermans-Kranenburg & van IJzendoorn, 2009; McCord, 1979; Robins, 1966; Marin-Avellan, McGauley, Campbell, and Fonagy, 2005,); insecure attachment and psychopathy in offenders (Frodi, et al.,; Gacono & Meloy, 1994; Schimmenti et al., 2014); adolescent psychopathy and insecure attachment (Flight & Forth, 2007); sexually coercive behaviour and insecure attachment (Barbaro et al., 2018; Langton et al., 2017; Ward & Marshall, 1996;); attachment insecurity

and sexual violence (Smallbone & Dads,1998**;** Chiffriller and Hennessy, 2010**;** Grattagliano et al., 2015; Barbaro et al., 2018); attachment insecurity and child molesting (Jamieson & Marshall, 2000; Marsa et al, 2004); and also between early relational trauma and psychopathy (Farrington, 2006, 2002; Graham, et al., 2012).

By the same token, Blair, Mitchell & Blair (2005) hypothesised that attachment abnormalities in early childhood cannot be considered as sufficient causal factors for the development of psychopathy, as the latter is a genetically-based disorder. Moreover, biologically oriented researchers believe that childhood maltreatment has minimal impact on the development of psychopathic personality as these patients are temperamentally immune to fear (Blair, 2008). Meloy (2005) proposed that pathology of attachment is an antecedent of psychopathy; however, he posited that the more severe the psychopathy is, the more neurobiologically rooted the aetiology will be.

Chronic emotional detachment in psychopathy is also reflected in the gold standard instrument for the assessment of psychopathy, namely the Psychopathy Checklist Revised (PCL-R; Hare, 2003). Schimmenti et al. (2014) suggested that item 11 (promiscuous sexual behaviour) and item 17 (many short-term marital relationships) can be considered as indicators of 'devaluation of attachment bonds' (DAB). By the same token, it is argued that interpersonal violence often occurs within an attachment bond, as "one of the great paradoxes of human existence" (Meloy, 2003, p. 509). It has also been hypothesised that item 2, namely 'Grandiose sense of self-worth', a core trait of the psychopathic personality, prevents the formation of any attachment bond as it demands 'a scornful and detached devaluation of others' (Gacono et al., 1992, as cited in Meloy, 2005, p. 78).

The relationship between attachment orientations and criminal psychopathy was also empirically measured by Schimmenti et al. (2014). In a sample of violent incarcerated

offenders housed either in prison and/or psychiatric hospitals, they found that most of the psychopathic patients in their study experienced early relational trauma; physical and/or sexual abuse; loss of a parent; and spent more than one year in foster care. In Schimmenti et al.'s (2014) study, no securely attached participants were found, whereas those ones who scored higher on the PCL-R also classified as having insecure attachments as well (Schimmenti et al., 2014). The authors, however, found that the PCL-R's devaluation of attachment bond's items (DAB) were intercorrelated and predicted PCL-R facet and total scores.

The findings of the studies presented in this section of the thesis provide further evidence for the theoretically proposed, and clinically observed relationship between attachment insecurity and violent offending. Considering the prevalence of psychopathic traits in forensic populations (e.g Hare & Neumann, 2010; Coid et al., 2009), the aforementioned studies that examined the contribution of attachment insecurity in violent offending, may also indicate a potential association between attachment insecurity and psychopathy as well. Despite their significance, particular studies examined the association between categorically diagnosed psychopathy at a cut off point 30 and insecure attachment used very small samples that do not allow the generalisation of their findings. Nevertheless, attachment appears to be an important factor in understanding violence in personality disorders and offending in general, and psychopathy in particular; the contribution of this factor, however, needs to be explored further.

2.2.5 Attachment Insecurity: Conclusions

Attachment theory has been widely utilised in the research of violent and antisocial behaviour. Recent neurobiological research supports Bowlby's (1951), Ainsworth's (1978)

and Mahler's (1979) findings with regard to the consequences of early socio-environmental stressors and maternal deprivation in the attachment bond in patients' childhoods (Ribeiro da Silva et al., 2015; Salekin & Lochman, 2008). Most salient to psychopathic personality appears to be a chronic emotional detachment from others, an attachment pathology that has been theoretically associated with emotional deprivation in early childhood. It is hypothesised that an early emotionally deprived environment could be considered one of the foundations of psychopathy.

2.2.6 Early Relational Trauma

The notion early relational trauma refers to chronic exposure to experiences of abuse and neglect (Terradas et al., 2020). Fonagy (2010) considered early relational trauma as the most destructive factor in an attachment relationship. It represents the most harmful manifestation of trauma as it disrupts the child's capacity to form a secure attachment with the caregiver (Allan, 2001; Beebe & Lachmann, 2014). Indeed, early relational trauma is catalyst for future emotional and psychological difficulties, including dysfunctional behaviour (Banker et al., 2019); disruptions in the attachment bond (Lahousen et al., 2019; Toof et al., 2020); and disturbance of mental functioning and the capacity to mentalise (Fonagy et al., 2002; Tessier et al., 2016; Terradas et al., 2020).

Early relational trauma can profoundly affect attachment behaviours (Scales & Scales, 2016; Cohen et al., 2016, West, 2016**)**. Furthermore, negative care childhood experiences can disrupt the development of healthy and secure attachments (Stinehart et al., 2012). Research has shown that there is a significant negative relationship between early relational trauma and secure attachment, whereas various forms of abuse were positive correlated with insecurities of attachment (Erozkan, 2016). This finding has empirically been confirmed by a number of

other studies who reported a relationship between attachment insecurity and early traumatic experiences (Stalker & Davies, 1995; Styron & Janoff – Bulman, 1997).

There are four types of attachment-related traumas within the attachment literature (Kobak et al., 2004). The first one refers to painful experiences of anticipated separation with the primary care giver and called *attachment disruptions*. Attachment disruptions do not refer to normal daily separations, but reflect prolonged unexpected separations which are difficult for the child to contain (Lyons-Ruth et al., 2005). The second type of attachment-related trauma refers to child's *physical or emotional abuse by the primary attachment figure*; the third type is *the loss of an attachment figure because of death*; and the fourth one is *attachment injuries*, as a result of the abandonment and neglect by the primary caregiver (Kobak et al., 2004; Johnson, 2002).

The prevalence of children who experienced physical trauma, which includes physical abuse, experiences of violence, natural disasters, or life-threatening illness, is high (Toof et al., 2020). Physical trauma appears to be associated with psychological difficulties later in life (Banker et al., 2019); avoidant and preoccupied attachment style **(**Gauthier et al., 1996). Childhood sexual abuse (CSA) is another severe type of trauma that included sexual assault, abuse and exploitation **(**SAMHSA, 2017, as cited in Toof et al., 2020). It is estimated that the prevalence rates for CAS approximately 20% for women and 8% for men **(**Stoltenborgh, van Ijzendoorn, Euser, & Bakermans- Kranenburg, 2011**),** whereas 70% of child abusers have experienced sexual abuse when they were children (van der Kolk, 2017).

The traumatic and overwhelming experiences in early childhood can contribute to the development of a disorganised attachment style; an attachment style that has been associated

with prolonged separations (Solomon et al., 1995) and sexual abuse (Lyons-Ruth & Block, 1996). One particular type of attachment disruption related to separation is when children removed from their primary caregivers (Hodges et al., 1999). Maltreatment, in general, has been associated with impulsivity **(**Cicchetti & Banny, 2014); deficits in aggression modulation (van der Kolk, 1987); difficulties in emotion regulation and higher rates of disorganisation (Lyons-Ruth et al., 1999). Moreover, maternal depression, hostility and substance abuse has also been linked with disorganised attachment; a style which is the most common attachment pattern among high-risk samples (Main & Hesse, 1990; Lyons-Ruth, et al., 1990; Lyons-Ruth et al., 2002)

According to the maltreatment – insecure attachment hypothesis, childhood maltreatment is considered as a causal factor for the development of insecure attachment (Langton et al., 2017). Many individuals who experience attachment related traumas, develop unresolved attachment representations; those individuals feel overwhelmed by the traumatic experiences or the memories of them (Hesse, 1996; 2008). Experiences of loss and abuse found to be predictive of unresolved attachments (Lyons-Ruth et al., 2003). Unresolved attachments have also been found in individuals who experience neglect (Riggs & Jacobviz, 2002).

2.2.6.1 Psychopathy and Early Relational Trauma

Early relational trauma has been considered an important antecedent of personality development, although the contribution of trauma has been debated (Goodman et al., 2004). In recent decades, however, there has been a considerable number of studies that have explored the link between early relational trauma and various manifestations of psychopathology (Lyons-Ruth et al., 2006; van der Kolk, 2005, 2014; van der Hart et al., 2006). Kessler et al. (2010) postulated that traumatic experiences in childhood account for 29.8% of all personality disorders. It is not always clear, however, whether or not, and how in particular the early aversive childhood experiences are related to various personality disorders (Berenz et al., 2014; Ma et al., 2016).

The majority of the studies presented in the preceding section (see Attachment Insecurity, Violent offending and Psychopathy) indicate that participants who were found to be insecurely attached reported more traumatic experiences. Other studies showed that insecurely attached psychopathic offenders reported more traumatic experiences, including various forms of abuse and neglect when compared with their non-psychopathic and non-violent offenders (Schimmenti et al., 2014; Frodi et al., 2001). Most importantly, those studies suggest that attachment insecurity and trauma are interrelated in offending populations (e.g Shimmenti et al., 2015).

The association between early relational trauma and violent offending has long been explored in forensic literature (Ardino, 2012). It is hypothesised that violent offending is a serious consequence of childhood maltreatment (Widom, 2017). Indeed, the prevalence of early childhood trauma in forensic populations are considerably high (Macinnes et al., 2016).

In a study of traumatic experiences amongst forensic mental health patients Spitzer et al., (2006, as cited in Macinnes et al., 2016) found prevalence rates of emotional and physical abuse at 69%; 47 percent sexual abuse; and 41% neglect. Other studies have suggested that there is an interlink between Post-Traumatic Stress Disorder (PTSD) and offending behaviour, with the prevalence of PTSD estimated at approximately 30% (Urbaniok, Endrass, Noll, Vetter & Rossegger, 2007). Those findings were supported by Spitzer et al. (2010) in a more recent study who found that more that 50% of forensic patients meet the diagnostic criteria for PTSD.

Adverse Childhood Experiences (ACEs) can lead to an increase risk of criminality and a range of violent behaviours (Fox, Perez, Cass, Baglivio, & Epps, 2015**;** Perez, Jennings, & Baglivio, 2018). Although the majority of the studies linking ACEs with criminality focus on young offenders (e.g. Graig et al., 2020), it appears to be an association between ACE and adult criminality (Reavis et al., 2012; Kim et al., 2016; DeLisi & Beauregard, 2018; DeLisi et al., 2014; Cuadra et al., 2014). Victims of Child Sexual Abuse (CSA), for instance, are more likely to engage in all types of offending behaviours, including violent and sexual offending (Papalia et al., 2018).

Early childhood trauma has also been linked with sexual offending (DeLisi et al., 2014; Levenson et al., 2015; Levenson et al., 2016). Grady at al. (2016) proposed a theoretical model linking adverse childhood experiences (ACEs) and insecure attachments to sexual offending behaviours. In their theoretical model Grady et al. (2016) proposed that both insecure attachments and ACE predict sexual offending behaviours. In a later study however, they found that sexual abuse was alone a sufficient factor predicting the commission of sexual crimes with no influence of from attachment style (Grady et al., 2016).

As was mentioned in the previous section, childhood adverse experiences have also been linked with a range of personality disorders, including borderline (Spataro et al., 2004), and antisocial personality disorder (Cicchetti & Banny, 2014**).** Nevertheless, research on the potential contribution of trauma to the development of psychopathic and sadistic personality remains largely unstudied (Craparo, 2013; Ireland et al., 2020).

Despite the scarcity of research, however, several researchers and clinicians have emphasized the importance of early childhood aversive experiences on the development of psychopathic disorder (Karpman, 1941; Kernberg, 1980; Lykken, 1995; Porter, 1996; Meloy, 2002; Juni, 2010; Caretti & Craparo, 2010). Moreover, environmental theories of psychopathy suggest that early relational trauma and abusive parenting is related to the emergence of psychopathic traits in adults (Porter et al., 1996; Frick, et al., 2005; Schimmenti et al., 2014; Schimmenti et al., 2015).

As was mentioned in the introduction, our present knowledge regarding the relationship between psychopathy and trauma is mostly based on single case studies. Nevertheless, most of those studies confirm the existence of a positive link between early aversive experiences and psychopathy (Beasley, 2004; Coid, Bruce-Jones, & Cold, 2013; Leach & Meloy, 1999; Nørbech, Crittenden, & Hartmann, 2013; Porcerelli et al., 2001).In addition to single case studies, however, a small but growing body of research has started to show that there appears to be a positive correlation between psychopathy and early traumatic experiences (Weiler & Widom (1996; Borja & Ostrosky, 2013; Craparo, 2013; Dargis, Newman, & Koenigs, 2016; RL et al., 2015; Schimmenti et al., 2015; Sevecke et al., 2016; Woodfield, et al., 2016;).

Amongst the most import research in this area was a study ran by Widom in 1989. The author followed up a sample of children with court-determined abuse from 1967 to 1971 and compared them with a control group with no history of abuse and neglect. Widom (1989) found that children who suffered abuse and neglect presented greater risk of criminal record later in their adulthood. The author also concluded that abused and neglected children had a higher frequency of getting arrested for violent offences as adults (Widom, 1989).

A few years later, Porter (1996) and Weiler & Widom (1996) challenged the widely held belief that genetic predisposition is alone insufficient to lead to the development of the psychopathic disorder. Drawing from clinical and research evidence, they emphasised the influence of negative care childhood experiences and suggested that traumatised children learn to 'switch off', or in other words to dismiss their feelings, in order to cope with the unbearable trauma.

Marshall and Cooke (1999) compared the early childhood experiences within a sample of psychopathic and non-psychopathic criminals to test the differences and the impact of those traumatic experiences on their participants. They found that adverse childhood experiences appear to be a risk factor for the development of psychopathy. These findings were supported by Lang et al. (2002) who assessed psychopathy with PCL-R on a sample of adults and concluded that high victimisation in childhood is linked with higher psychopathy scores. Other research reported correlations between early traumatic experiences and psychopathy (Warren & South, 2006).

A few studies appear to suggest that factors during early infancy can predict the development of psychopathic traits. No exposure to breast feeding and a shorter duration of breast feeding were found to be a risk factor for the development of psychopathic traits in adulthood (Jackson & Beaver, 2016). Other studies have identified early parenting factors

that have been found to predict callous-unemotional (CU) traits in childhood (Kerig et al., 2012). Wagner et al. (2015; 2017) found that less sensitive parenting predicts CU traits, whereas maternal sensitivity is a protective factor associated with lower CU traits. Viding et al. (2014) also suggested that parental responsiveness and mirroring of a child's emotions prevent the development of CU traits.

Psychopathy was found to be significantly associated with PTSD (Blackburn et al., 2003; Blonigen et al., 2012). Kubak & Salekin (2009) also found that psychopathy in juvenile offenders was also correlated with PTSD. In contrast, Moeller & Hell (2003) found that PTSD was negatively correlated with psychopathy as non-psychopaths reported higher PTSD scores than psychopaths.

Craparo et al. (2013) examined the potential association between early traumatic experiences and psychopathy in a group of violent offenders in Italy. They found a high prevalence of childhood relational trauma, which assessed by the Traumatic Experience Checklist (TEC), amongst the participants who obtained high PCL-R scores. The authors further reported a negative association between the age of the first early relational trauma and PCL-R scores. In general, the results of the study showed a high prevalence of traumatic experiences of neglect and abuse amongst the violent populations (Craparo et al., 2013).

Borja & Ostrosky (2013) explored the relationship between trauma and psychopathy in a sample of 194 violent offenders in Mexico. They used the PCL-R to assess psychopathic traits, whereas the Early Trauma Inventory (ETI) was administered to measure the early traumatic expriences. The results of their study confirmed that psychopaths were exposed to a greater extent to specific types of abuse and presented a higher victimisation level than sociopathic inmates (Borja & Ostrosky, 2013). The authors did not recruit sexual offenders,

so it is unclear whether those traumatic experiences were present in sexually violent psychopaths.

Krstic et al. (2016) examined the contribution of physical, sexual and emotional abuse in a sample of 397 adult male sex offenders. They found that different types of abuse covaried with total PCL-R score; however, they associated with facet scores at a different level. Sexual abuse predicted Lifestyle and Interpersonal facets; physical abuse predicted Lifestyle and Antisocial facets, whereas emotional abuse was negatively correlated with the Affective facet (Krstic et al., 2016). Further research into environmental factors indicates that negative care childhood experiences are associated with an impulsive and antisocial lifestyle (Graham et al., 2012; Poythress et al., 2006) as well as with high psychopathy scores (Lang et al., 2002).

These results were mirrored by a more recent study by Schimmenti et al. (2015). The authors used the Traumatic Experienced Checklist (TEC) to assess traumatic experienced in a sample of 78 violent and sexually violent offenders recruited from various Italian prisons. The results showed that 64% of the participants experiences either physical, sexual or emotional abuse; 22% experienced two types of abuse; and 17% experienced all the aforementioned types of abuse. Statistical analyses revealed that psychopathy total scores, measured by the PCL – R were correlated with emotional abuse in childhood; whereas physical and sexual abuse were positively associated with the antisocial and lifestyle faces. Emotional abuse also predicted PCL-R Factor 1 and Factor 2, a finding that supports the hypothesis that emotional abuse in childhood is a strong predictor of psychopathy scores. These findings are also confirmed by another recent study by Schimmenti et al. (2014), who found that offenders with the highest psychopathic scores, suffered the severe traumatic experiences.

Notwithstanding the importance of the aforementioned studies empirically support the hypothesis that early traumatic experiences are corelated with psychopathy, they are not without limitations. Amongst those limitations are the use of different samples used (i.e. specific offenders, adults or adolescents; failure to consider the PCL-R facets and how they are related to particular traumatic experiences; use of small samples that do not allow the generalisation of the results; and also, the absence of data on whether early childhood maltreatment is specifically related to violence, sexual violence and sadism amongst psychopathic patients. Moreover, some studies were carried out within homogenous groups (e.g. sexual offenders) so it is still unknown whether there are differences in trauma between sexual and non-sexual psychopaths, as well as between sadistic and non-sadistic psychopaths. Nevertheless, research indicates that the relationship between early childhood trauma and psychopathy needs to be explored further.

Some of these limitations were captured by a recent systematic review, which followed by an expert Delphi by Ireland et al. (2020). Although the systematic review supported a potential association between early traumatic experiences and psychopathy, it demonstrated important limitations. Those limitations were primarily related to how trauma was captured (e.g. trauma symptoms as opposed to diagnosis, absence of the developmental mechanisms by which psychopathy could possible develop from trauma). Drawing on Karpmans (1941) model of psychopathy the authors highlighted the significance of emotional abuse, which was related to secondary psychopathy. Equally, trauma severity predicted secondary psychopathy, whereas primary psychopathy was related to the severity of physical trauma. Nevertheless, there were no differences in trauma type between psychopathic and non- psychopathic patients (Ireland et al., 2020). Consequently, the findings need to be

interpreted with caution, and any proposed association between psychopathy and early relational trauma cannot be conclusive, as research has shown that no all individuals who experience trauma present psychopathy, and vice versa.

2.2.7 Affective Deficits in Psychopathy

As presented above, research has shown that affective deficits are central to the psychopathic personality (Willemsen & Verhaeghe, 2012). The most significant affective features of psychopathy are the profound lack of guilt and empathy, which have long been considered as the building blocks of antisocial and criminal behaviour (Blair et al., 2006; Cleckley, 1941; Hare, 2003; Hare & Neumann, 2008). Blair (2005) considered lack of empathy to be the underlying aetiological factor for the majority of psychopathic traits. Indeed, affective deficits have been amongst the most prominent aetiological hypotheses for the existence of aggression within the psychopathic personality (Blair et al., 2005; Patrick, 2007).

Psychopaths' affective deficits have been empirically measured. Psychopathy has been found to be negatively correlated with empathy (Edens, Marcus, Lilienfeld, & Poythress, 2006; Flight & Forth, 2007; Mullins-Nelson, Salekin, & Leistico, 2006) and fear conditioning (Blair et al., 2005). Although affective deficits constitute the core of psychopathy, there is a perennial debate on whether they have an exclusively neurobiological basis (such as deficits in the amygdala) (Blair, 2001; Blair et al., 2005); are based on developmental factors that parallel the neurobiological abnormalities (Kernberg; 1980; Hare, 2003; Meloy, 2002); or are subject to socio-economic factors (Cleckly, 1941; Bowlby, 1969; McCord & McCord, 1964; Juni, 2010).

The difficulty of assessing the presence of affective deficits in psychopathy is mainly related to psychopaths' conning and manipulative behaviour (Cleckey, 1941; Hare, 2003; Porter & Woodworth, 2007). Despite the deficits in affective empathy in psychopathic patients, research suggests that cognitive empathy remains unimpaired (Mullins-Nelson et al., 2006). Indeed, psychopaths can exploit emotional language without experiencing any underlying feelings. Cleckley (1941) used the term 'semantic aphasia/dementia' to refer to the psychopath's ability to use emotional language 'as if' they can experience feelings. The psychopath is a notorious 'liar par excellence' (Karpman, 1947; Karpman, 1949). They malinger, deceive and manipulate others. This behaviour appears to be influenced by impairments in affective empathy, and by the total absence of remorse and guilt in psychopathy (Hare, 2003).

2.2.8 Further Aetiological Theories of Psychopathy

When considering aetiology, as stated at the beginning of this section, the contributions of genes and environment should be considered. Today, there are various hypotheses about the development of psychopathy. Low fear theories of psychopathy are amongst the most influential ones. Lykken (1957, 1995) suggested that lack of fearfulness is a crucial mechanism in the development of psychopathy. He used the term 'fear quotient' to refer to psychopath's innate fearfulness, as well as their attenuated experience of fear (Lykken, 1957).

Another theory of reduced fearfulness in psychopathy refers to the behavioural inhibition system (BIS), and the behavioural activation system (BAS) (Gray, 1970). The BIS is a biological system that determines someone's sensitivity to punishment, whereas, the BAS determines how the individual's behaviours are influenced by a potential reward (Fowles, 1987). It is argued that reduced responsiveness to punishment is a risk factor for the

development of psychopathy, a finding that was also clinically observed by Cleckley (1941), who suggested that psychopaths commit crimes even if there is a strong possibility of getting caught. It is further suggested that psychopathy is the result of an overactive BAS system and an underactive BIS system (Fowles & Dindo, 2006).

A further influential aetiological theory, which was briefly mentioned earlier, is the Violence Inhibition Mechanism (VIS) (Blair, 1995; Blair, Mitchell & Blair, 2005). The VIM describes a mechanism that prevents an individual from committing violent acts when they notice their victims' distress to their violent actions. The VIM, therefore, can be considered as an agent of moral socialisation that prevents us from committing violent acts when witnessing distress in others. In psychopathy, however, it is hypothesised that VIM does not function properly as psychopaths do not respond to others' distress (Blair, Mitchell & Blair, 2005).

2.2.9 Environmental Antecedents: Conclusion

Drawing from literature review, the developmental origins of psychopathy are marked by attachment insecurities; aversive and traumatic experiences during early childhood; prolonged separation from the mother and maternal deprivation. It is hypothesised that these aversive behaviours and attachment abnormalities are at the very foundation of psychopathic and sadistic behaviour and have been associated with psychopathic and sadistic traits; violence; sexual violence; antisocial and criminal behaviour. However, there is very little empirical research that examines the relationship between early environmental antecedents, psychopathy and sexual sadism.

Indeed, very few studies have examined the environmental factors that contribute to the development of psychopathy and sexual sadism and most of the studies suffer from methodological limitations. Most of the theories about the aetiology of psychopathy and

sexual sadism derive from single case studies and, currently there is no empirical model that explains the development of both constructs. Therefore, there is a need for more information about the relationship between psychopathy and sexual sadism and how they are developmentally linked to violence, sexual violence or sadistic behaviour.

2.3 AGGRESSION LITERATURE REVIEW

2.3.1 Introduction

Aggression is a complex and ubiquitous phenomenon with significant costs to society. As mentioned earlier, psychopathy and sexual sadism have been associated with inordinate amounts of aggression. This section will seek to review the literature regarding the function, type, and nature of aggression within psychopathy and sexual sadism, and also how it is manifested through violent and sexually violent behaviour.

Aggression is also a heterogeneous phenomenon and has been conceptualised in various ways. Despite the imposing volume of research, definitions of aggression still create confusion in forensic studies. Since Darwin (1859) there exists a perennial debate about the definition, nature, and function of aggression in human beings. Considering the biological, social and psychological determinants of aggression, contemporary research dichotomises the phenomenon into distinct, but not always interrelated categories (Kockler, Stanford, Nelson, Meloy, & Sanford, 2006).

It is hypothesised that this confusion stems from the fact that aggression has often been used to denote both the psychological drive, and also its most significant pathognomonic, namely violence (Cartwright, 2002). Moreover, most of the definitions of aggression are dogmatically oriented towards the nature-nurture dichotomy and not how nature shapes nurture and, of course, vice versa (Stolorow & Harrison, 1975).

It is argued that the construct of aggression deserves a more sophisticated understanding that goes beyond a mere bimodal classification. For this reason, it is necessary to provide an in-depth review of aggression, and this is what this section aims to do. First, it will explore the current definitions of aggression and violence. Second, it will present a psychobiological model of aggression based on recent neurobiological and psychological

findings. Third, it will move on to a discussion about the function, neurobiology and psychodynamics of instrumental and reactive aggression, and present how the fundamental differences in the nature and dynamics of aggression lead to the diagnostic formulation of distinct types of psychopathy. Finally, the section will discuss how sexuality is intertwined with aggression in the construct of sexual sadism.

2.3.2 Conceptualisations of Aggression and Violence

As mentioned in the introduction, much of the confusion regarding the phenomenon of aggression derives from a lack of a clear distinction between the former and violence. Nonetheless, the differentiation between aggression and violence is critical to the understanding of both phenomena within the psychopathic personality (Meloy, 2002). The pluralism in the definitions of aggression within the literature, however, results in difficulties distinguishing the two phenomena. More recently, Coccaro (2012, as cited in Coccaro, Lee, & Mccloskey, 2014) defined aggression as 'a multi-determined verbal and/or physical act that results in physical/psychological injury to others and/or destruction of property/ other objects' (p. 526). The Cambridge dictionary defines aggression as a 'spoken or physical behaviour that is threatening or involves harm to someone or something' (Cambridge essential English dictionary, 2011), whereas, in the Oxford dictionary, aggression is defined as 'hostile or violent behaviours or attitudes' (Thompson, 2000).

The above conceptualisations, however, do not reflect a clear psychological distinction between aggression and violence. Most congruent with the hypotheses of this thesis is Valzelli's (1981, as cited in Meloy, 2002) definition of aggression as a 'component of normal behaviour which, under different stimulus-bound and goal directed forms, is released for satisfying vital needs and for removing or overcoming any threat to the physical and/or psychological integrity subserving the self- and species- preservation of a living

organism, and except of predatory activity, initiating the destruction of the opponent' (p. 191).

This definition reflects both the biological and the psychological function of aggression in human beings. From a biological perspective, aggression is a life-protecting force that aims to maintain the preservation of the self and species. Psychologically, aggression protects the integrity of the self, leading to a stage of internal homeostasis, where all the threats to the (psychological) self are eliminated.

Violence, on the other hand, is the pathological manifestation of aggression (Kernberg, 1998). It derives from an inordinate activation of the psychological drive of aggression. As the pathognomonic of aggression, violence can be better conceptualised as 'an intentional act of physical aggression against another human being that is likely to cause physical injury' (Meloy, 2006, p. 539). Although aggression does not necessarily result in violence, it is the core element of every violent behaviour (Meloy, 2002).

2.3.3 A Psychobiological Model of Aggression

Valzelli's (1981, as cited in Meloy, 2002) definition of aggression is empirically supported by the seminal work of Otto Kernberg on personality disorders (1980). Based on the neurobiological level of personality development, as well as the early relationships with the primary caregivers, which are internalised and form the subjective intrapsychic world of the individual's object relations, Kernberg offers a comprehensive explanation of the phenomenon of aggression within the concept of personality.

Personality can best be defined as an umbrella concept, codetermined by both genetic and neurobiological predispositions, as well as socio-environmental factors (Kernberg, 2016). The most fundamental constitutive element of personality is temperament, which includes cognitive and neurobiological affective systems and 'refers to the constitutionally given and

largely genetically determined, inborn disposition to certain reactions to environmental stimuli' (Kernberg, 2004, p. 6). These neurobiological affective systems, which are called affects, are hierarchically superior motivational systems that determine human behaviour (Kernberg, 1991). Further, these primary motivational systems (affects) have a two-fold task: to relate the individual to their environment in terms of either positive or negative reward, and secondly, to trigger specific neurotransmitters (serotonin, dopamine, and noradrenalin) and brain structures when an environmental requirement appears (Kernberg, 2016).

Affects, therefore, are the constitutional and instinctive elements of human behaviour that are genetically common to all human beings and emerge at the earliest stages of development (Kernberg, 2004). Aggression is the general designation of all the negative and painful affects (Kernberg, 1998). As the representative of all aversive affects, aggression is manifested in mammals and has various aims including the defence of territory, elimination of threatening stimuli and protection of the infant. In humans, however, severe early physical or psychological trauma at very early developmental stages can cause pathologies in the neurobiology of affects which determine aggression, and this will result in an excessive activation of the latter (Kernberg, 1998).

The importance of the communicative role of affects in the early stages of development in general, and the child-mother relationship in particular, can activate negative affective states. This is the argument that underlies all models of reactive aggression, where aggression is associated with early traumatic experiences and/or attachment insecurity with the primary caregivers (Bowlby, 1944, 1969; Fairbairn, 1952; Fonagy et al., 2017; Kohut, 1972; Winnicott, 1956). In contrast to the reactive nature of aggression, the theory of instrumental aggression proposes that aggression is primarily neurobiologically oriented and, therefore, is not affected much by socio-environmental factors (Blair et al., 2005).

Research, however, has shown that aggression cannot be conceptualised as a one-dimensional phenomenon (Coccaro, Solis, Fanning, & Lee, 2015; Juni, 2009a; Meloy, 2002) as one kind of aggression does not necessarily have only one origin or function (Cartwright, 2002). With regard to psychopathy and sexual sadism, forensic research has shown that reactive and proactive aggression are not mutually exclusive as research has shown that psychopathic and sadistic patients engage in both modes of aggression (Burt, 2012; Cale & Lilienfeld, 2006; Cornell, 1996; Declercq & Maleval, 2012; Glenn & Raine, 2009, 2014; Juni, 2009a; Kernberg, 1980; Kockler et al., 2006; Meloy, 2006; Meloy & Reavis, 2007; Woodworth & Porter, 2002; Raine et al., 1998).

2.3.4 The Instrumental/Predatory mode of Aggression

Psychopathy has empirically been conceptualised in the context of instrumental/predatory aggression (Blair, 2007; Juni, 2010; Meloy, 2006; Woodworth & Porter, 2002; Patrick et al., 2009). Research has established that psychopathic offenders tend to engage in instrumental modes of violence (Blair, 2010; Blais, Solodukhin, & Forth, 2014; Cornell, 1996; Meloy, 2006; Woodworth & Porter, 2002), whereas non-psychopathic offenders tend to engage mostly in a reactive mode of aggression (Glenn & Raine, 2009, 2014; Meloy, 2006). Several researchers suggest that the psychopath's impulsive behaviour is associated with reactive modes of aggression (Blair, 2010; Porter et al., 2001) whereas psychoanalytic oriented researchers have proposed that poor impulse control does not form a manifestation of characterological psychopathy (Juni, 2010).

Instrumental/predatory is characterised as the mode of aggression which is purposeful, cognitively planned, and results in the destruction of the victim (Meloy, 2006a). Predatory aggression in psychopathic individuals aims to achieve a desired goal and is an end in itself (Cornell, 1996; Vitaro, Brendgen, & Barker, 2006). In the literature, predatory

aggression has often been referred to as instrumental, premeditated or proactive; however, there are not conceptual differences between these terms (Anderson & Kiehl, 2014). The term 'predatory' is chosen as a more sophisticated term that reflects accurately psychopaths' predatory nature and will be used throughout this section.

Predisposition to the predatory mode of aggression, in the context of psychopathy, is strongly linked with the psychopathological structure of the disorder (Siever, 2008). Individuals who engage in predatory aggression present stronger psychopathic traits as measured by PCL-R (Kockler et al., 2006). Indeed, predatory aggression is characterised by the lack of emotion, which is central in psychopathy (Hare, 2003). It is often considered as an emotionless and cold-blooded type of violence that reflects a psychopath's callous and unemotional traits (Lynam, Caspi, Moffitt, Loeber, & Stouthamer-Loeber, 2007; Lynam et al., 2011).

Psychopaths are less likely to commit a crime under intense emotional arousal; a finding that also supports the hypothesis that psychopathic individuals engage in predatory violence more often that non-psychopathic individuals (Glenn & Raine, 2009). Further evidence suggests that offenders who engage in predatory modes of aggression have also been found to be significantly more psychopathic compared to non-aggressive offenders as well as to groups who have displayed reactive aggression (Lane, Tcheremissine & Lieving, 2007, as cited in Glenn & Raine, 2009). Recent studies in youths have also demonstrated that lack of empathy and affective deficits can predict predatory violence (Flight & Forth, 2007; Hazebroek, Olthof, & FA, 2017), whereas reactive violence is primarily associated with the antisocial facet of psychopathy (Flight & Forth, 2007; Adrian Raine & Yang, 2006).

Indeed, a psychopath's lack of empathy functions as a deterrent for predatory violence (Blair, 2001). Neurobiological findings suggest that predatory violence is biochemically and

neuroanatomically distinct from reactive violence (Meloy, 2006; Raine & Yang, 2006). Predatory violence, as the predominant mode of violence in psychopathy has been associated with early structural and functional dysfunction in the amygdala, whereas orbitofrontal cortex lesions are associated with reactive aggression (Blair, 2007; Blair, 2008; Blair, 2001; Kiehl, 2006; Kiehl et al., 2001; Kiehl & Hoffman, 2011; Stone, 2009; Viding et al., 2014). A psychopath's neuroanatomical abnormalities distinguish psychopathy from the other forms of psychopathology and suggest that paralimbic circuitry is a trigger for both reactive and predatory violence (Anderson & Kiehl, 2014).

Although neurobiological impairments are considered as risk factors for predatory and reactive aggression, they cannot be considered as aetiological factors of violent behaviour (Glenn & Raine, 2009). Glenn and Raine (2009) advocate that 'an abnormality in a particular brain region does not imply that the abnormality was the cause of a specific behaviour or crime' (p. 257). Following the same reasoning, Blair (2001) proposed that aggression in psychopathy can also be triggered by the failure to represent the mental states of others (mentalisation), suggesting that a theory of the mind is important in understanding emotional states in psychopathy.

Reid Meloy (1997a, 2006) offered a unique classification of violence applied in forensic practice. His classification is an integration of recent neurobiological findings combined with psychodynamic research. Meloy (2002, 2006) proposed ten criteria for applied practice that have been tested empirically by several studies (Raine et al., 1998; Barratt, Stanford, Kent, & Felthous, 1997; Stanford et al., 2003; Gottman et al., 1995; Stanford et al., 2003, as cited in Declercq & Audenaert, 2011) and present good psychometric qualities and interrater reliability. Those criteria were particularly used to distinguish between

affective and predatory murderes in Raine et al (1998), and presented excellent interrater reliability (Kappa = 0.86).

According to Meloy's findings (2002, 2006), predatory aggression in humans presents ten distinct but interrelated neurobiological, behavioural and intrapsychic characteristics. The most remarkable neurobiological marker of predatory aggression is the total absence or arousal of the autonomous nervous system prior to the violent act, accompanied by the peripheral autonomic hyporeactivity (Meloy, 2002; Anderson & Kiehl, 2014). Autonomic arousal results in increased heart rate and arterial constriction that prepares the individual to enter into an alarm state (Declercq & Audenaert, 2011; Declercq, Willemsen, Audenaert, & Verhaeghe, 2012). However, in psychopaths a psycho-physiological state of alarm is absent; therefore, there are no behavioural indicators before the violent act (Meloy, 2006).

The absence of behavioural indicators is also associated with a further absence of any conscious experience of emotion prior to predatory violence (Meloy, 2002). The only emotion that psychopathic individuals usually report is a feeling of exhilaration, which is not prevalent during the act of predatory violence but prior to this, when the victim is stalked. The psychopath is notorious for his thrill-seeking behaviour and commits crimes out of pleasure (Porter & Woodworth, 2006) even when the risk of getting caught is high (Willemsen & Verhaeghe, 2009). From a psychoanalytic point of view, the absence of any conscious emotion is explained due to the use of the primitive defence mechanism of projective identification and omnipotent control, which protect the psychopath's grandiose self-structure (Kernberg, 1980; Klein, 1946).

The absence of autonomic arousal, conscious experience of emotions and behavioural indicators prior to predation leads to the hypothesis that predatory violence is intentional, planned and purposeful (Meloy, 2006). Furthermore, in predatory violence, the immediacy of

a perceived threat or a stressor and the consequent affective reactivity is virtually absent as well. There is a total absence of any imminent threat that may impinge the psychopath either on a biological level (self-preservation) or a psychological level. Additionally, predation serves multi-determined and variable goals, unlike the reactive violence that aims to minimise the perceived stressor (Meloy, 2001).

Another distinct characteristic of predatory aggression is the absence of displacement of the target of aggression (Meloy, 2002, 2006): the psychopath ignores everything and predominately focuses on the object of predation. Two additional characteristics of predatory violence are the time-unlimited behavioural sequence, due to the absence of autonomic and affective arousal, and the presence of a private ritual, which has a two-fold aim; on the one hand, it enhances the psychopath's feelings of grandiosity and narcissism and on the other, ameliorates any feelings of fear or anxiety he feels (Meloy, 2002).

Indeed, a private ritual before or after a murder is a very maladaptive process that helps psychopaths to ward off painful emotions (Arrigo & Griffin, 2004). Recent forensic studies have proposed that the presence of ritualism is a distinct manifestation of sadism (Longpré, Guay, Knight, & Benbouriche, 2018; Longpré, Proulx, & Brouillette-Alarie, 2018; Mokros et al., 2012). Further, Meloy (Meloy, 2002, 2006) has associated predation with two other factors: the predominance of cognitive – process rather than affective arousal, and a heightened and focused sensory awareness as the psychopath is exclusively focused on his prey.

Several studies have provided further evidence that psychopaths appear to be predisposed to predatory mode of aggression. Meloy and Gacono's (1994) made this conclusions relying on hundreds of Rorschach tests Woodworth and Porter's (2002) study showed that psychopaths are twice as likely (93.3%) to commit a predatory homicide when

compared to non-psychopaths (48.4%). Other researchers (e.g Porter et al., 2003) suggested that the instrumental and predatory modes of aggression are distributed dimensionally, and they constitute two different categorical entities. By the same token, psychodynamic and attachment researchers (Fonagy, 2003) have not paid much attention to the concept of predatory violence with few exceptions (Glasser, 1998; Yakely & Meloy, in press, as cited in Meloy, 2012).

2.3.5 Affective/Reactive Aggression

Affective aggression, which is also referred to as 'impulsive' or 'reactive' in the literature, is the most common mode of aggression characterising the vast majority of human violence (Meloy, 2006). In mammals, this type of aggression is triggered for the protection of territory and the inborn from predators. Affective aggression, in its normal manifestation, is a life preserving force; is characterised by intense anger, emotional arousal and fear as it aims to protect the self from a perceived threat or provocation (Blair, 2010). Nonetheless, in humans, in contrast to animals and other lower organisms, aggression has an additional symbolic and psychological function; it protects both the physical and also the psychological self (Fonagy, 1999; Fonagy et al., 2017; Stolorow & Harrison, 1975). As mentioned earlier in the chapter, predatory and affective modes of aggression follow different neuroanatomical pathways. Following Meloy's (Meloy, 2002, 2006) empirically established criteria for aggression in forensic practice, affective violence also presents ten distinct characteristics that distinguish it psychologically and neurobiologically from instrumental aggression.

At a neurobiological level, affective violence is preceded by intense arousal of the autonomous nervous system (Anderson & Kiehl, 2014; Blair, 2010; Glenn & Raine, 2009, 2014, Meloy, 2002, 2006). Cellural homeostasis is being threatened; the amygdala, hippocampus and prefrontal cortex send signals; norepinephrine, dopamine and acetylcholine are released; heart rate is elevated, breathing and oxygen levels are increased and the organism enters into an 'alarm state' (Anderson & Kiehl, 2014; Meloy, 2006). This state is dynamically characterised by the conscious experience of two basic emotions: fear and anger.

Affective aggression has been associated with the frustration-anger model (Berkowitz, 1989) and the social learning theory of aggression (Bandura, 1978). Freud (1905a, 1905b) first conceptualised aggression as a response to frustration of the sexual drive; he initially

understood aggression as secondary to frustration. Moreover, the conceptualisation of aggression as a reaction to frustration, or to internal or external threat, was supported by many clinicians who rejected the existence of an instrumental mode of aggression (Bowlby, 1969; Fairbairn, 1952; Hartmann, Loewenstein, 1949; Hartmann, 1958; Kohut, 1972, 1977; Fromm, 1973). In this context, affective violence is perceived as a reaction to an externally or internally perceived threat. Violent outbursts, which are usually the pathognomonic of affective aggression, aim to return the organism to a state of homeostasis. At the physiological level, affective violence refers to life preserving force; at the psychological level, it refers to the protection of the psychological self (Fonagy et al., 2017).

The concept of the psychological self is differentiated from the physical self. Fonagy et al. (1992) distinguished between a pre-reflective/non-psychological self and the reflective or psychological self. The non-psychological self refers purely to the physical self and is established by the first six months; whereas, the psychological self, 'the internal observer of mental life' (p. 271), is established in the first two years of life (Fonagy et al., 1992). A child's psychological self is built through his interaction with the primary caregiver. A child's mental (emotional) states develop through the interaction with the mother; he internalises his mother's emotional states, which form his own mental states and internal working models (Bowlby, 1969; Fairbairn, 1952).

Research in early infancy (Fonagy et al., 1991b, as cited in Fonagy et al., 1992) has shown that parents who were not able to 'reflect on their own intentions or those of others in their narrative accounts of their own childhoods' (p. 273), had disorganised and avoidant one-year-old infants. Furthermore, in families where the primary caregiver does not have the reflective capacity to mirror the child's feelings, or she is excessively controlling, paranoid and even abusive, the child's emotional development is severely disturbed (Cartwright,

2002). As a consequence of inadequate and emotionally vacuous parenting, the child develops a very fragile sense of the self.

Indeed, abusive parenting and more specifically failure of the mother to reflect the emotional and mental states of the infant, are considered major aetiological factors that lead to the developments of affective aggression (Augsburger et al., 2017; Kernberg, 1994; Siever, 2008; Weierstall et al., 2013). As discussed earlier, the emotionally deprived and abused child develops a grandiose self-structure that protects them from intolerable pain and suffering. In contrast to the common belief that the psychopath is a monstrous criminal who does not experience any feelings, recent research indicates that psychopaths are able to experience pain in their interpersonal relationships (Gullhaugen & Nøttestad, 2012; Martens, 2001, 2008; Nørbech et al., 2013; Sundt Gullhaugen & Aage Nøttestad, 2011b). In this context, affective aggression is conceptualised on the spectrum of the frustration-aggression hypothesis, and is considered as a response to the vulnerability of self-representations (Stolorow & Harrison, 1975).

Affective aggression has been further associated with early traumatic experiences and post-traumatic stress disorder symptoms (Augsburger et al., 2017; Siever, 2008; Weierstall et al., 2013). Individuals who engage in affective acts of violence are predisposed to anxiety (Raine et al., 2006; Adrian Raine & Yang, 2006) as those acts of violence are triggered by a past trauma (Siever, 2008). Although research has shown that anxiety is absent in psychopathy, a number of researchers have posited that psychopathy and anxiety are not mutually exclusive (Bate et al., 2014; Edens et al., 2006; Hare & Neumann, 2010; Karpman, 1941; Lykken, 1995; Skeem et al., 2007; Willemsen & Verhaeghe, 2012). These research findings may be provide further support to Karpman's (1941) notion of primary and secondary psychopathy. Karpman (1941) theorized that primary psychopaths have a

genetically affective deficit, and therefore cannot respond to anxiety, whereas secondary psychopaths are characterized by elevated anxiety, impulsivity and anger. A psychopath's interpersonal and affective traits, however, protect him from the experience of a specific manifestation of anxiety, namely post-traumatic stress disorder (Willemsen, De Ganck, & Verhaeghe, 2012).

Affective aggression in psychopathy has often been conceptualised in terms of narcissistic rage (Kernberg, 1991; Kohut, 1972), in which aggression is viewed as the response to the frustration of the omnipotence of the grandiose self-structure. As presented in the previous chapter, what behaviourally differentiates the psychopath from other severe narcissistic personality disordered individuals is that psychopaths develop a defensive protection for their grandiose self that is based on violence, instead of protecting it in phantasy, as narcissistic patients do. Further research in infancy confirms that rage is a primary affective state and its biological function is to eliminate a source of pain and irritation by signalling this state of pain to the caregiver (Kernberg, 1991).

The nature of rage, as a core manifestation of affective aggression cannot only be conceptualised as a drive, but also as a result of insecure attachment (Bowlby, 1944; Kernberg, 2014; Winnicott, 1971). Following this rhetoric, rage is the reaction to perceived self-damage, 'a response to humiliation, a threat to the self-esteem and well-being of the individual' (Cartwright, 2002, p. 25). Due to traumatic attachment to a frustrating caregiver, rage can be transformed to hatred and envy, which are the primary affective states in psychopathy (Klein, 1957; Meloy, 2001).

2.3.6 Sadism: When Aggression meets Sexuality

The concept of sadism was based on the life and writings of the 18th century French aristocrat and novelist Marquis de Sade (1740-1814), who was notorious for his sexually

deviant behaviour. The term 'sadism', however, was initially coined by Krafft-Ebing who, in his revolutionary work *Psychopathia Sexualis* (1886, 1965) defined the latter as 'the experience of sexual pleasurable sensations (including orgasm) produced by acts of cruelty, bodily punishment, afflicted on one's own person or when witnessed in others, be they animals or human beings' (Millon et al., 2004, p. 530). For Krafft-Ebing, sadism was not a sexual phenomenon per se; the infliction of physical and psychological pain on others reflects the individual's character pathology, where physical and/or psychological suffering is perceived as an end in itself (1937, as cited in Millon et al., 2004).

At the beginning of the 20th century, Sigmund Freud (1905b) and his pupil Wilhelm Stekel (Stekel, 1929) offered a comprehensive understanding of sadism from a clinical perspective. Freud initially considered aggression as a drive for sexual mastery over a human being (Freud, 1905b). He conceptualised sadism as a partial drive of the libido, which is strongly and unconsciously motivated by sexual strivings (Freud, 1905b). From this theoretical angle, sadism (and masochism) can be regarded as perversions (Freud, 1905a). In his later work (1915), he moved from the idea that sadism is secondary to the basic sex drive and conceptualised it as a response to the frustration of libidinal drives. The introduction of the theory of drives initiated the formulation of aggression as an innate manifestation of the drive, which was not rooted in pleasure, but rather in destruction (Freud, 1923).

Following Freud's theoretical speculations, Erich Fromm (1973) distinguished between an active and a passive manifestation of sadism. He theorised that the two manifestations of sadism can coincide or exist separately (Fromm, 1973). He named the active manifestation of sadism *algolagnia*, which is defined as the derivation of pleasure through the subjection and control of others (Fromm, 1973). For Fromm, active sadism is not necessarily related or blended with sexuality, in contrast to the passive manifestation, in

which sadism is expressed as the wish to cause physical pain to the sexual partner. For individuals who are afflicted with this type of perversion, sadism is the only way to feel sexually excited and released (Fromm, 1973).

Currently, the most comprehensive conceptualisation of sadism comes from Theodore Millon (2004). He proposed four distinct but interrelated manifestations of the sadistic personality: the explosive; tyrannical; enforcing and spineless sadist (Millon et al., 2004). From an interpersonal angle, Millon's sadist controls, taunt and violate the rights of others. Cognitively, he tends to exploit other people for his own benefit, and biologically he shares similar phylogenetical features with psychopathic personalities (Millon et al., 2004).

Surprisingly, our current understanding of (sexual) sadism has not been considerably extended since Krafft-Ebing and Freud first conceptualised it (Knoll & Hazelwood, 2009). This lack of progress in understanding sadism has often been linked to the difficulties in defining and measuring the construct (Marshall & Hucker, 2006; Marshall et al., 2002). These difficulties in the definition and measurement of sadism, along with the low prevalence rate of the disorder in clinical settings have led the research community not to consider sadism as a formal diagnosis anymore (Millon, 1981). In the DSM III (American Psychiatric Association, 1980) sadism was conceptualised as a personality disorder (sadistic personality disorder) characterised by a maladaptive and severely aggressive pattern of behaviour, clearly differentiated from antisocial personality disorder (Millon et al., 2004).

Nonetheless, in DSM IV (American Psychiatric Association, 2000) and DSM 5 (American Psychiatric Association, 2013) sadism is not classified as a personality disorder but considered as paraphilia under the name of 'sexual sadism'. According to Millon (2004) this reduction derived from scientific concerns due to the low prevalence rate of sadism in

clinical settings. However, 'burning the map does not eliminate the territory' (Meloy, 2001, p. 174).

Indeed, sexual sadism has been defined ambiguously in the DSM. The DSM V has classified sadism as a paraphilia considering only the sexual manifestation of sadism. It describes sexual sadism as 'recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviours' for a period of at least six months (American Psychiatric Association, 2013, p. 695). Furthermore, the patient is considered as a sexual sadist if he 'has acted on these sexual urges with a non-consenting person, *or* the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning' (American Psychiatric Association, 2013, p. 695, italics added).

The above definition includes both the preoccupation with sadistic sexual fantasies, as well as the acting out of these phantasies. Stone (2010) suggests that the term should ideally be used for those who act out on sexual sadistic fantasies. So, the main problem with DSM's definition is the word 'or', that means that a patient can be diagnosed as a sexual sadist either if he has sexual fantasies only, *or* if he exhibits sexually sadistic behaviours (Stone, 2010).

The second problem that Stone (2010) identified is again related to the word 'or'. According to DSM 5, sexual urges or behaviours cause severe distress or dysfunction (American Psychiatric Association, 2013). There are, of course, patients who have a well-developed internalised moral structure that suffices control their sadistic fantasies from any acting out. By the same token, there is another category of sadistic patients, usually seen in secure hospitals and prisons. These patients cannot experience feelings of remorse or guilt and a great majority meet the criteria for psychopathy (Stone, 2010; Juni, 2009b). This

indicates that the DSM definition is overinclusive and in need of disambiguation (Stone, 2010).

There has been debate over whether sexual sadism represents a distinct diagnostic category from other forms of sadism (e.g. sadism as a trait, or sadism as a disorder of personality) (Krueger, 2010). In the contemporary literature, definitions of sexual sadism indeed vary. Meloy (2002) defines sexual sadism as 'the conscious experience of pleasurable sexual arousal through the infliction of physical or emotional pain on the actual object' (p. 76). Holt et al. (1999) defined sexual sadism as a subtype of sadism that involves sexual arousal that derives from a trait or psychodynamic. Juni (2009b) argued that sadism is an endogenous character pathology and sexual deviance is only peripheral to it.

Despite the definitional problems around sadism, there appears to be a general consensus within the research community that sadism is conceptualised as a paraphilia, rooted in sexual arousal, fantasies, urges or violent and humiliating behaviours that aim to subjugate and inflict pain on the victim (Dietz, Hazelwood, & Warren, 1990; Knight, Prentky, & Cerce, 1994; MacCulloch, Gray, & Watt, 2000; Marshall & Hucker, 2006; Mokros et al., 2011; Robertson & Knight, 2014). In contrast to the conceptualisation of sadism as a purely sexual phenomenon, some researchers and clinicians expanded the understanding of sadism beyond sexuality and conceptualised sadism as a disorder of personality rather than a paraphilia (Fromm, 1973; Holt et al., 1999; Juni, 2010; Meloy, 1997b; Millon et al., 2004).

The theoretical stance of this thesis is congruent with the depiction of sadism as a severe character pathology, rather than as a paraphilia (Fromm, 1973; Holt et al., 1999; Juni, 2010; Meloy, 1997b; Millon et al., 2004). According to this point of view, sexuality in sadism is subsidiary and not the core component of the construct (Juni, 2009b; Fromm, 1973).

Sadism consists of a cluster of behaviours 'from nonsexual physical or mental cruelty and domination, to sexual torture before murder' (Holt, Meloy & Strack, 1999, p. 28). In this context, sexual sadism is conceptualised as a subtype of sadism, manifested as the wish to cause physical pain to the other. Furthermore, sexual sadism has also been conceptualised as 'the conscious experience of pleasurable sexual arousal through the infliction of physical or emotional pain on the actual object' (Meloy, 2002, p. 76).

Central to the understanding of sadism as endogenous character pathology, is the differentiation between sadistic behaviour and sadistic personality (Millon et al., 2004). The most significant markers of sadistic personality are the infliction of physical and/or psychological pain and the derivation of pleasure that comes through the subjugation, humiliation devaluation and control of others (Healey, Lussier, & Beauregard, 2013; Kernberg, 1998; Marshall & Kennedy, 2003; Meloy, 1997b).

From a psychoanalytic point of view, the devaluation of others in terms of total submission and omnipotent control is considered as a defence mechanism against a sadist's feelings of envy (Kernberg, 1980). The victim is experienced as the needed object and at the same time, as the creator of the need, therefore is hated and envied by the sadist. Although sadists are incapable of experiencing feelings of empathy and they can't form emotional bonds with other people, they do, however, present the need to retain their grandiose self-picture and a sense of self-centeredness. Their need to maintain their narcissistic equilibrium is based on their profound need to obtain admiration and to be approved by other people (Kernberg, 1975). Consequently, the people who reflect their narcissistic needs become the 'needed objects'.

Cotemporary research on attachment behaviour appear to confirm these psychodynamic findings. Attachment studies have shown that insecure and avoidant

attachment in childhood is associated with aggression; fear of rejection and abandonment; relationship insecurity; and specifically related to sexual violence and sadism in adulthood (Barbaro et al., 2018; Bogaerts, Vanheule, & Declercq, 2005; Dutton, 2007; Langton et al., 2017; Nguyen & Parkhill, 2014; Russell & King, 2016). Further studies have suggested that hostile masculinity, which arises from poor parenting and insecure parental attachments, is associated with sexual aggression, sexual assault and perpetration (Barbaro et al., 2018).

Clinical work with severely sadistic patients demonstrates that they developed an early attachment to an abusive parent (Juni, 2009a) which psychodynamically is referred to as 'identification with the aggressor'; a pattern also found in psychopaths. The sadist oscillates between abuse and intimacy. Sadism involves re-enactments of unresolved traumatic childhood events and conflicts (Stein, 2004; Macgregor, 1991; Fox & Levin, 1994, as cited in Knoll & Hazelwood, 2009). Although sadists' violent actions initially seem motiveless, object relations theory conceptualises them as phenomena of repetition compulsion. In short, the sadist replays a traumatic situation from the past in order to repair severe interpersonal and attachment disturbances (Juni, 2009b; Meloy, 2001).

Sexuality in sadism often facilitates and echoes painful childhood experiences (Cartwright, 2002; Stone, 2010). It appears that sexual transgressions are not aetiologically sexual per se; sexuality is not expressed as a phenomenon of eroticism, but coalesces with aggression in the service of the latter (Juni, 2009b). The sadist tries to overcome past traumas and ameliorate his internal pain by involving himself in phenomena of repetition-compulsion. This aggressive mode of engagement and their drive to humiliate others have their roots in old traumatic experiences, whether the victims stand in a sadist's phantasy as key figures of the past.

2.3.7 Sadism and Psychopathy

As was stated in the beginning of this thesis, psychopathy and sadism have been associated at a theoretical and a clinical level throughout the literature. Empirical research has shown that both constructs link to predatory violence (Meloy, 2002; Robertson & Knight, 2014); sexual offending and sexual homicides (Gacono et al., 1995; Knight, 2010; Knight & Guay, 2006; Porter et al., 2001); emotional detachment from the suffering of others (Kernberg, 1998; Mokros, Osterheider et al., 2011; Porcerelli et al., 2001; Stone, 2009); primitive object relations structure (Juni, 1997, 2010; Kernberg, 2014; 2002); and non-sexual violence (Porter & Woodworth, 2006).

Sadism has also been proposed as a distinct manifestation of psychopathy (Juni, 2009a; Murphy & Vess, 2003). Although sadism shares common ground with psychopathy in terms of developmental and emotional deficits, the key criterion that differentiates sadism from psychopathy is the mode of violence. Psychopaths appear to engage mostly in predatory violence (Blair, 2001; Glenn & Raine, 2014; Meloy, 2002), whereas violence in sadists is initially predatory by turns into affective during the sadistic act (Meloy, 2002). The most significant marker of sadism is the desire to control others through the enjoyment of hurting and dehumanising them. In contrast, in psychopathy the intent is the destruction of the other; the suffering of the victim is not always a manifestation of psychopaths' repertoire. Sadism, however, reflects an attempt to 'destroy the victim beyond death' (Knoll & Hazelwood, 2009, p. 109).

Despite the theoretical and clinical interface of psychopathy and sexual sadism, very few studies have attempted to empirically measure the relationship between these two constructs (Darjee, 2019; Holt et al., 1999; Mokros et al., 2011; Robertson & Knight, 2014; O' Connel & Marcus, 2019). These studies have shown that there is a significant covariation

between psychopathy and sexual sadism. Holt, Meloy and Strack (1999) found that sadism is positively correlated with the interpersonal and antisocial facet of the PCL-R, a finding that was also confirmed by Mokros et al. (2011), as well as Robertson & Knight (2014). Mokros et al. (2011) and Robertson & Knight (2014) found that psychopathy and sexual sadism are positively correlated, a finding that was not confirmed by Holt, Meloy and Strack (1999) probably due to insufficient data.

Although these studies demonstrate a significant relationship between psychopathy and sadism, they have methodological limitations. First, the sample for the most recent studies (Mokros et al., 2011; Robertson & Knight, 2014) derived from archival ratings. According to Hare (2003) there are difficulties in providing an accurate assessment of psychopathy based exclusively on archival ratings, which can be affected by observer bias. Furthermore, the assessment of sadism requires interpersonal variances that need to be assessed through an interview. Holt, Meloy & Strack's (1999) study assessed the relationship between psychopathy and sadism through personality tests, clinical interviews and review of collateral information; however, the assessment of sexual sadism was predominately based on DSM criteria that present poor interrater reliability (Nitschke et al., 2012).

2.3.8 Assessment of Sexual Sadism

Despite theoretical pluralism, there is a very little consistency regarding the defining characteristics of sexual sadism (Marshall & Hucker, 2006; Marshall et al., 2002). Consequently, the measurement of sadism is mired in controversy; there is a lack of dimensional and reliable instruments, and research on sadism confirms the vital need for the development of such instruments (Krueger, 2010).

It has been hypothesised that the problems in the assessment of sexual sadism derive from the conceptualisation of sadism as a one-dimensional, homogenous, and distinct

nosological entity (Marshall & Kennedy, 2003; Mokros, Schilling, Weiss, Nitschke, & Eher, 2014). Further, the absence of any pathognomonic symptoms has made the diagnosis of sexual sadism very elusive (Marshall & Kennedy, 2003; Millon et al., 2004).

Regarding the issues of validity and reliability, the diagnosis of sadism is fraught with controversy. The current psychiatric diagnosis of sadism relies on either the Diagnostic and Statistical Manual of Mental Disorders (DSM 5; American Psychiatric Association, 2013) or the International Classification of Mental and Behavioural Disorders (ICD-10; World Health Organization, 1992). The two systems follow relatively similar criteria but have considerable differences as well. The most fundamental difference is that the ICD-10 uses the term *sadomasochism*, describing the same diagnostic category for both sadism and masochism, whereas the DSM 5 classifies sadism and masochism as distinct diagnostic categories.

In contrast to the current categorical approach proposed by the DSM, a growing body of research has supported the hypothesis that sadism is a dimensional construct and not a distinct categorical diagnosis (Longpré et al., 2018; Longpré, Guay, & Knight, 2017; Longpré et al., 2018; Mokros et al., 2014; Knight et al., 2013). The severity of sadistic behaviour can vary across a spectrum, ranging from physical cruelty (MacCulloch et al., 2000; Marshall et al., 2002; Meloy, 2001) to severe sexual sadism (Knight et al., 2013; Knight, 2010; Nitschke et al., 2012).

Another considerable difficulty with regard to the assessment of sexual sadism, is that the diagnostician cannot accurately determine whether sadism is the main source of sexual arousal, and thus he needs to rely on self-report measures unless he has access to adequate information (Nitschke et al., 2012). Considering the significant difficulties with the definitions of sexual sadism, the lack of consensus, as well as the poor interrater reliability of diagnosis based on DSM 5 or ICD-10 criteria, some authors introduced the use of

behavioural indicators derived from patients' offence history, as a complementary and more reliable measure for sexual sadism (N. Longpré et al., 2018; N. Longpré, Proulx, & Brouillette-Alarie, 2016; Marshall & Kennedy, 2003; Mokros et al., 2012; Nitschke et al., 2012).

2.4 Hypotheses

Based on a review of the literature, a number of hypotheses have been generated which this study aims to test (Chapters 5 and 6). Based on both prior research and theory it is anticipated that psychopathy and sexual sadism will show developmental antecedents in high-risk UK prisoners and forensic mental health patients and that those antecedents will be related to violent, sexually violent, and sadistic behavior. Furthermore, it is expected that a positive correlation will be observed between psychopathy and sexual sadism, as well as psychopathy and trait sadism. Despite the theoretical associations, there is only a small body of research considering the association between the two constructs, as well as the environmental factors that predict their development.

Sexual Sadism and Psychopathy

Psychopathy and sadism have been theoretically and clinically linked to violence, sexual offending and sexual homicides (Porter et al., 2003; Robertson & Knight, 2014), as well as to non-sexual offending (Holt et al., 1999; Porter & Woodworth, 2006). Despite the theoretical overlap and the interrelation between psychopathy and sadism, very few studies have explored the covariation between the two constructs (Holt et al., 1999; Mokros et al., 2011; Robertson & Knight, 2014). Based on the review of the literature and previous empirical research, it is anticipated that there will be a positive correlation between psychopathy and sexual sadism.

Hypothesis 1: Sexual sadism will show a significant association with psychopathy.

Trait Sadism and Psychopathy

Although several studies have tried to empirically assess the comorbidity between sexual sadism and psychopathy, it is not clear whether sadism is a key trait in the constellation of psychopathy. The PCL-R does not include sadism as a distinct item;

however, it does include item eight, *callous/lack of empathy* that might denote sadistic behaviour (Hare, 2003). Research on psychopathy using the Rorschach test has shown that psychopaths are related to other people in terms of control, power and domination rather than affection (Meloy et al., 1994).

Hypothesis 2: Trait sadism will show a significant association with psychopathy.

Attachment insecurity in sexual sadism and psychopathy

Based on the review of the literature, central to psychopathy is a chronic emotional detachment from others (Juni, 2010; Kernberg, 1980; Meloy, 2002). Empirical and infant research on attachment has shown that poor attachment styles predict development of affectionless psychopathy (Bowlby, 1969); sexually coercive behaviour (Langton et al., 2017); and antisocial behaviour (Gacono & Meloy, 1994). Research suggests that there appears to be a negative relationship between secure attachment and psychopathy in adolescents (Flight & Forth, 2007), and a positive relationship between parental dysfunction and psychopathic traits (Netland & Miner, 2012). Anxious/insecure parental attachment are considered as predictors of sexual violence (Barbaro et al., 2018; Russell & King, 2016). Nevertheless, the relationship between attachment styles and psychopathy remains largely unexplored. Currently there has been no research that explores the relationship between attachment, sexual sadism and psychopathy among forensic mental health patients.

Hypothesis 3: Attachments in both sadistic and non-sadistic psychopaths will be more anxious, insecure and dismissing compared to non-psychopaths.

Hypothesis 4: Attachment abnormalities will be associated with sexual sadism.

Hypothesis 5: Attachment abnormalities will be associated with psychopathy.

Trauma, psychopathy and sexual sadism

The association between early traumatic experiences and criminality has been well demonstrated in the literature. However, little is known about the link between physical and/or psychological trauma and its contribution to the development of psychopathy and sadism. Several researchers have supported the idea that psychopathy is aetiologically rooted in early traumatic exposure in childhood (Cleckley, 1941; Juni, 2009b; Karpman, 1941; Kernberg, 1975; Lykken, 1995; Meloy, 2002; Porter, 1996). Craparo, Schimmenti & Caretti (2013) used the PCL-R and the T.E.C in a sample of violent offenders and found that higher levels of early relational trauma are associated with higher scores on the PCL-R. Furthermore, Willemsen, Ganck & Verhaeghe (2012), examined the interaction between psychopathy, trauma and posttraumatic stress in a sample of 81 offenders and found that the interpersonal and affective features of psychopathy protect psychopaths against post-traumatic stress. However, the relationship between early childhood trauma and psychopathy in patients, who present sadistic traits, has not been researched yet.

Hypothesis 6: Sadistic psychopaths will present higher levels of early childhood trauma compared to non-sadistic psychopaths.

Hypothesis 7: Exposure to trauma during early childhood is associated with the development of more severe sadistic and psychopathic traits.

Hypothesis 8: Adverse experiences will be associated with sexual sadism.

Hypothesis 9: Adverse experiences will be associated with psychopathy.

CHAPTER 3

METHODOLOGY

3.1 Introduction

The three aims of this study were to: 1) examine the relationship between psychopathy, sexual sadism and trait sadism, 2) identify the early environmental antecedents, such as attachment abnormalities, neglect, early relational trauma and adverse childhood experiences that contribute to the development of psychopathy and sexual sadism, and 3) explore how these antecedents are related to violence, sexual violence and sadistic behaviour in psychopathic and sadistic mental health patients.

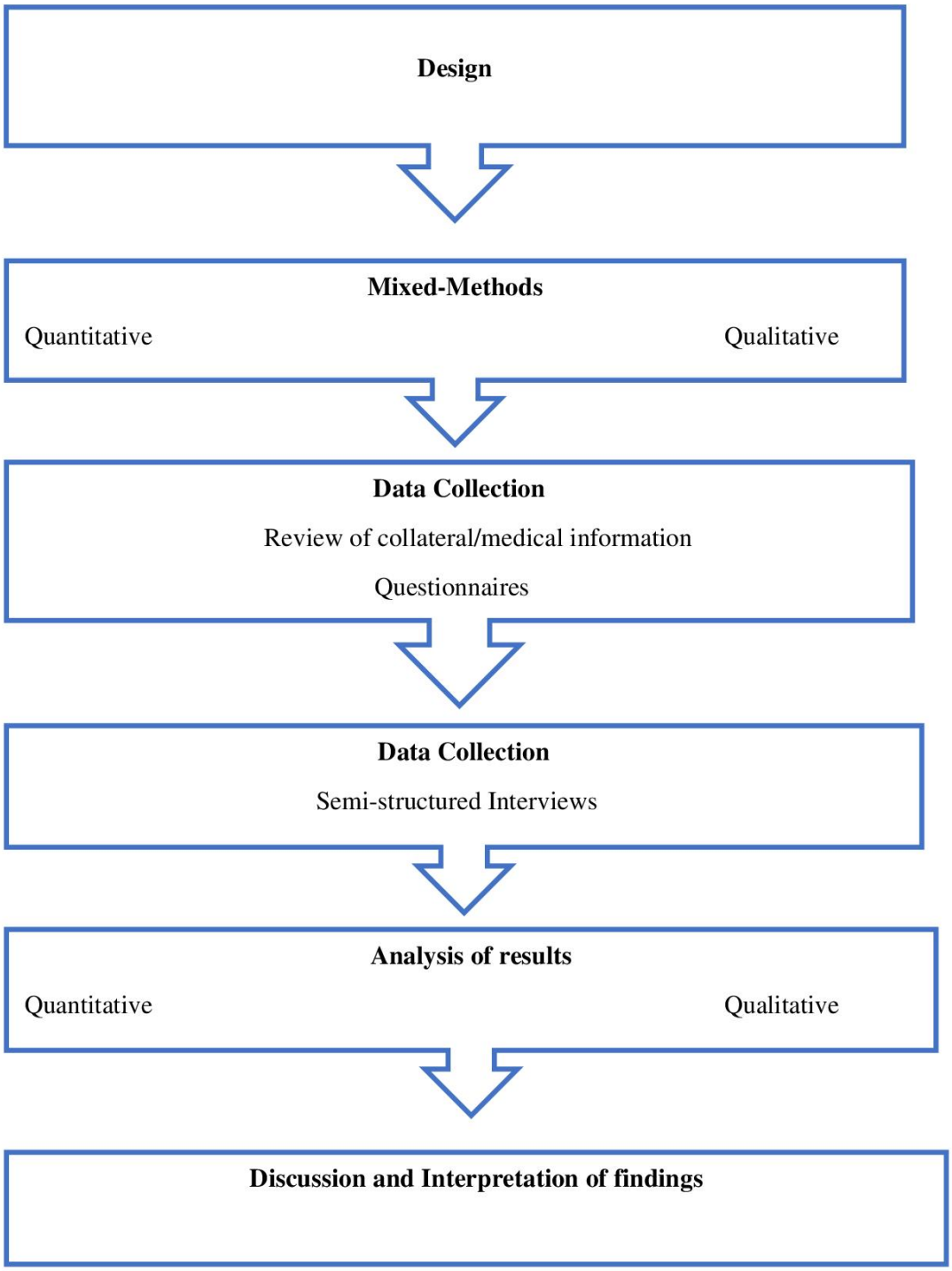
Despite the theoretical and clinical association between adverse environmental factors, psychopathy, and sexual sadism, very few studies have attempted to explore this relationship. As previously reviewed (see Chapter 2), these studies suffer from significant methodological limitations that make their results questionable. First, the assessment of psychopathy was predominantly based on self-report measures and not on the Psychopathy Checklist Revised (PCL-R), which is considered the gold-standard instrument for the assessment of psychopathy. Secondly, most of the studies used very small samples that do not allow for generalisation of the data. Moreover, the vast majority of the studies were conducted in non-clinical populations (students), and, therefore, it is not clear how the environmental deficits are linked with manifestations of violent and aggressive behaviour (sexual or non-sexual, sadistic or non-sadistic).

3.2 Design Rationale

This section outlines the design processes, the theoretical framework and the methods used in this study. A mixed-method design was employed in this study, as it was most suited for addressing the research aims of this thesis. Mixed-method research is defined as a philosophically underpinned model that involves the combination of a qualitative and quantitative approach to collecting and analysing data (Creswell & Tashakkori, 2007; Creswell & Plano Clark, 2007). This mixed-method research design allowed for rich conceptualisation of each developmental factor and testing for the relationship between environmental antecedents, psychopathy and sexual sadism.

The mixed method provided comprehensive data in order to answer the research questions and achieve the objectives of the study. There are four different types of mixed-method research, namely triangulation, embedded, explanatory and exploratory (Teddlie & Tashakkori, 2009). The explanatory model was most appropriately chosen for this study. This model first contains the qualitative data collection, which is subsequently followed by the qualitative data collection in order to provide a deeper understanding of the findings of the study. The details of the research design of the present study are schematically illustrated in Figure 1.0.

Figure 1: Research Design



3.3 Participants

The current research project is a mixed-method study, involving paper-based questionnaires, behavioural scales, and semi-structured interviews. Given the focus of the study on the developmental origins of psychopathy and sexual sadism, and on how these developmental antecedents link with violent, sexually violent and sadistic behaviour, a forensic mental health population was chosen as the most appropriate to answer the questions and meet the objectives of the study.

Sixty-two (62) male participants were recruited for this study. Fifty-six (56) participants were service users in the personality disorder services who were allocated to secure mental health hospitals within the National Health System (NHS), as part of their pathway plan and treatment. Six (6) participants were offenders incarcerated in Frankland Prison, who at the time of the study, were undertaking treatment within the Westgate Personality Disorder unit. Participant selection was based on the type of offence they had been convicted for prior to their admission to the hospital/prison. Three (3) participants decided to withdraw from the study.

More specifically, participants were selected if they were convicted for violent or sexually violent offences (e.g. rape, sexual homicide), as defined by the Sexual Offences Act (2003) and the World Health Organization[6] (WHO). Participants were classified as violent if they had never been convicted for a sexually violent crime. By the same token, participants were classified as sexually violent if their offences contained sexual elements.

[6] 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work' (Krug et al., 2002, p. 149).

Research participants were recruited if they were between 18 and 70 years old, had the capacity to communicate in English, and did not display positive psychotic symptoms (such as hallucinations or delusions). The age restriction was implemented in order to exclude adolescents, due to their ongoing personality and brain development (Stone, 2009) as well as elder populations who may be suffering from degenerative brain disorders (e.g. dementia). Although the assessment of sexual sadism and psychopathy in adolescents and the elderly is important, this task was beyond the scope of this study. No restrictions were applied to participation that related to attributes such as ethnicity, race, gender, religion, culture or sexual orientation.

3.4 Mixed-method procedures

3.4.1 Participant selection

The participants who met the inclusion criteria for the study had been initially identified through file review and then by consultation with the responsible clinician at each site. The responsible clinician informed the researcher about the patients who do not have the capacity to participate, and who, therefore, had to be excluded from the study. The researcher was given access to patients records, where he, alongside the responsible clinicial, screened the patients with regards to their type of offence (i.e. violent and/or sexually violent offences); the presence of sexual sadism; and their PCL-R diagnosis.

Next, the researcher was invited to the group/therapeutic community meetings that take place fortnightly in each secure setting to present his research. During those meetings the researcher introduced his study to the patients and allowed space for discussion and questions. The researcher sought informed consent from all the participants assuring them that he did not intend to use any identifiable information about them in any subsequent

publication, report or other derivative from the study. The consent forms, as well as the participant's information sheets, initiated and informed the participants about the purpose of the study and were gathered separately for both the quantitative and qualitative parts of the study.

Participants' rights and freedom of choice were protected throughout the study. To minimise the possibility of coercion, the participants were approached by the lead researcher, who distributed the consent forms and supplied them with an information sheet. Participants were given 24 hours to consider their involvement, and the completed consent forms were subsequently collected by the researcher in collaboration with local staff members. One copy of the signed consent form was kept on file and one given to the participant.

The participants were adequately aware of the purpose and details of the study, the anticipated benefits and potential risks, and the discomfort the study may entail along with appropriate actions in such circumstances and their right to abstain from participation or withdraw consent to participate at any time without reprisal. However, in the event that criminal or other disclosures which warrant further action occurred, the researcher, as clearly stated in the consent form, made the participants aware that he would be obliged to relay this information to the staff team.

With regard to the semi-structured individual interviews, the researcher requested the interviews to be conducted in private, without the presence of staff or other service users. The researcher initially approached the participants who met the criteria for the qualitative interviews and distributed the consent forms and supplied them with an information sheet. Participants were given 24 hours to decide whether they wanted to participate in the second stage of the study. The duration of interviews varied, ranging between 20' to 90'. All interviews were transcribed and pseudonymised by the lead researcher.

3.5 Measures

3.5.1 Assessment of Psychopathy

Psychopathy Checklist Revised (PCL-R) and Psychopathy Checklist: Screening Version (PCL:SV)

The assessment of psychopathy was based on the existing, clinician-rated classification criteria of the Psychopathy Checklist-Revised (PCL-R; Hare, 1993, 2000) and/or its shorter version, the Psychopathy Checklist: Screening Version (PCL:SV; Hart, Cox, & Hare, 1995). As described in Section 1.1.6, the PCL-R is a 20-item instrument scored on the basis of file information and an interview. Each of the 20 items can be scored as 0 (the psychopathic trait is absent), 1 (the psychopathic trait is somehow present), and 2 (the psychopathic trait is definitely present), to a total score that ranges from 0-40. The widely accepted cut-off point of psychopathy is a score equal to or greater than 30 (Hare et al., 2000); however, in Europe, a score equal to or greater that 25 is usually accepted as a cut-off point for psychopathy (Willemsen, & Verhaeghe, 2009).

A considerable body of research indicates that PCL-R is the gold-standard instrument for assessing psychopathy due to the reliability, internal consistency, and validity that it displays (Hare & Neumann, 2008). Evidence demonstrates that the reliability of PCL-R items across six samples has been found to be at 0.88; and internal consistency across 11 samples at 0.87 (Shine & Hobson, 1997). According to Hare (1991, as cited in Shine & Hobson, 1997) PCL-R has good content, concurrent, predictive validity, interrater reliability across diverse populations, as well as 'convergent and discriminative abilities' (Shine & Hobson, 1997, p. 548).

3.5.2 Assessment of Sexual Sadism

DSM 5 & ICD - 10

As aforementioned, there is little consensus regarding the diagnosis of sexual sadism. The most common method for assessing sexual sadism is through clinical evaluation based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5; American Psychiatric Association, 2013) and the *International Classification of Mental and Behavioral Disorders* (ICD-10; World Health Organization, 1992). Although the two instruments present relatively similar diagnostic criteria, the most fundamental difference is that, in the ICD-10, the term *sadomasochism* is used to describe the same diagnostic category for both sadism and masochism, whereas the DSM V classifies sadism and masochism as two distinct diagnostic categories.

In this study, sexual sadism was measured by using the two current psychiatric diagnostic manuals: The *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (APA; 2013) and the *International Classification of Mental and Behavioural Disorders, 10th edition* (ICD-10; World Health Organization, 1992). Nonetheless, as presented in Chapter 2, research has shown that an assessment of sexual sadism exclusively based on DSM V and ICD-10 criteria has been associated with many difficulties.

First, the two nosological instruments do not distinguish between the relevance of the diagnosis of sexual sadism in forensic settings and the consenting practice of sadomasochistic role play, which is not linked to the traumatisation of the person (Mokros, Schilling, Eher, & Nitschke, 2012). However, DSM V differentiates paraphilia, which is more similar to consensual sadomasochism, and paraphilic disorder that involves a higher degree of severity (APA, 2012). There is indeed a profound lack of consensus and poor interrater reliability

amongst the diagnosticians in evaluating sexual sadism based on DSM and ICD, and this is affected by the sample and the methodology of the research, where κ values can range from .14 to .93 (Nitschke et al., 2012).

Critical to the diagnosis of sexual sadism in a forensic setting is whether sadism is considered as the main source of sexual arousal, and for this reason, the diagnostician needs to rely on self-report measures (Nitschke et al., 2012). However, research has shown that sexual offenders are reluctant to reveal malevolent fantasies related to coercion. Therefore, clinicians have to make hypotheses based on distorted or very limited information, which reduces the reliability of the study (Nitschke et al., 2012).

Considering the aforementioned hindrances and discrepancies in the assessment of sexual sadism within forensic settings, several researchers suggested the use of behavioural indicators that derive from a person's offence history, as a complementary and more reliable measure for sexual sadism (Longpré et al., 2016; Marshall & Kennedy, 2003; Mokros et al., 2012; Nitschke et al., 2012). In the current study, a validated behavioural scale that evaluates sexual sadism through 11 items that describe sadistic fantasies and behaviours, namely the Severe Sexual Sadism Scale (SESAS; Nitschke, Osterheider, & Mokros, 2009), was used to assess sexual sadism.

Severe Sexual Sadism Scale (SESAS)

The Severe Sexual Sadism Scale (SESAS) is a behavioural scale for the file-based assessment of severe sexual sadism in forensic settings (Appendix 13). SESAS is comprised of a set of 11 criteria that describe sadistic behaviours and fantasies (Nitschke et al., 2012). The development of the 11-item SESAS (formerly SSSS) was based on Marshall and Hucker's (2006) work; they developed the Sexual Sadism Scale (SSS), comprised of 17

criteria. The psychometric properties of the SSS were evaluated by Nitschke et al. (2009) and the resulting scale included 11 out of the 17 criteria originally set by Marshall and Hucker (2006).

The first 5 items of the SESAS are considered as core items (Longpré et al., 2016). All of the 11 items are behavioural apart from the first one (*Offender is sexually aroused by sadistic acts*) that describes a physiological state. Each item in the SESAS is coded as absent (0) or present (1), using a score of 4 out of the 11 as a cut-off point (Nitschke et al., 2012). The SESAS presents good psychometric properties: high interrelated agreement (k=0.86), good discriminant validity and internal consistency (a=.75) (Longpré et al., 2016; Nitschke et al., 2012). More recently Longpré et al. (2016) assessed the validity of the SESAS and its degree of convergence with other nosological instruments and found a significant correlation between the SESAS scores and DSM IV diagnosis of sexual sadism. The sum score in the SESAS presented significant correlation with the total score on PCL-R (r=.29) (Mokros et al., 2012).

The SESAS was constructed to assess severe sexual sadism in the forensic settings but may be less effective at assessing less intense sadism or consensual types of sadomasochism (Longpré et al., 2016). Kruger (2010, as cited in Nitschke et al., 2012) claims that there is a lack of empirical evidence to support the inclusion of behavioural scales as alternative diagnostic instruments for sexual sadism. However, SESAS was developed to complement the DSM and ICD and thus it should not replace the current nosological instruments (Nitschke et al., 2012). Given the discrepancies in assessing severe sexual sadism in forensic settings, as well as the low interrater reliability of the sexual sadism diagnosis using the DSM and ICD, SESAS can usefully complement DSM and ICD (Nitschke et al., 2012).

3.5.3 Assessment of trait sadism

Assessment of Sadistic Personality (ASP; Plouffe, Saklofske, & Smith, 2017)

The *Assessment of Sadistic Personality* (ASP) is a 20-item questionnaire developed in 2017 by Plouffe and her colleagues (Appendix 12). The ASP has been constructed to measure sub-clinical sadism based on 20 questions that reflect sadistic traits, such as lack of empathy, subjugation and pleasure-seeking. Participants are asked to respond to the questions on a 5-point Likert scale (1= strongly disagree, 5= strongly agree). Research has demonstrated that the ASP presents good convergent validity and reliability, whereas factors analyses have shown that sadism, as measured by the ASP, is related to psychopathy and narcissism (Plouffe et al., 2017).

3.5.4 Assessment of attachment abnormalities

Revised Adult Attachment Scale (RAAS; Collins & Read, 1990)

The Adult Attachment Scale is an 18-item questionnaire developed in 1990, by Collins and Read (Appendix 9). The RAAS is an instrument that measures adult attachment style dimension. The construction of the scale was based on Hazen & Shaver's prototypical descriptions (1987), which were categorised in 18 items. Participants are asked to rate their 'feelings about romantic relationships' using a 5-point Likert scale. The scores on the RAAS yield three attachment styles: Secure (high scores on Close and Depend subscales, low score on Anxiety subscale), Anxious (high score on Anxiety subscale, moderate scores on Close and Depend subscales) and Avoidant (low scores on Close, Depend, and Anxiety subscales).

Each subscale is composed of 6 items. The CLOSE subscale assesses the extent to which a person is comfortable with intimacy and closeness. The DEPEND subscale measures the extent to which an individual can rely or depend on others. The ANXIETY subscale

reflects the extent to which someone is worried about being abandoned or unloved. The close, depend, and anxiety dimensions can be used in combination to describe the discrete styles of attachment, namely secure, avoidant, and preoccupied (Collins and Read, 1990).

RAAS' alternative scoring includes broad attachment dimensions, namely *attachment anxiety* (model of self) and *attachment avoidance* (model of other). Attachment anxiety is comprised of 6 items, whereas attachment avoidance includes 12 items. Collins & Read (1990) found that test-retest correlations for a two-month period for Close, Depend and Anxiety were .81, .78 and .85 respectively. For the purpose of this study, attachment anxiety and attachment avoidance will be utilised.

Relationship Scales Questionnaire **(**RSQ; Griffin & Bartholomew, 1994**)**

The Relationship Scale Questionnaire (RSQ) consists of 30 items that describe the participant's 'feelings about close relationships', 'romantic relationships' or 'orientations to a specific relationship' (Appendix 10). Participants are asked to rate their feelings on a 5-point Likert scale, ranging from 1 (*not at all like me*) to 5 (to *very much like me*). The items of this self-report are based on Hazan and Shaver's (1987) scales; Bartholomew and Horowitz's (1991) relationship questionnaire; and Collins and Read's (1990) revised adult attachment scale.

By evaluating two dimensions of anxiety and avoidance, scores on the RSQ yield four attachment categories: *secure* (items 3, 9, 10, 15, 28), *preoccupied* (6, 8, 16, 25), *dismissing* (2, 6, 19, 22, 28), and *fearful* (2, 6, 19, 22, 28). Items 6, 9 and 28 are reverse-scored. The RSQ was designed to provide dimensional scores for each of the four attachment orientations, or a two-dimensional score view of the self (anxiety) and the other (avoidance). Griffin & Bartholomew (1994) suggested that the four attachment styles can be derived by calculating the mean score of the items of each subscale. The questionnaire's 2 dimensions of anxiety

and avoidance display very good internal consistency, ranging from 0.85 to 0.90 (Shvil, 2011). Retest reliability for the RSQ ranges from 0.54 to 0.78 (Bartholomew & Horowitz, 1991).

Given the specific population of this study and the reason for identifying attachment abnormalities only for the purpose of research and not for clinical use, the RSQ was selected as an appropriate self-report measure that captures different attachment orientations. Furthermore, the RSQ does not require much time to complete, has low levels of intrusiveness and it can be scored simply. The questionnaire has also been used in previous studies with forensic populations (Baker & Beech, 2004; Ward, Hudson, & Marshall, 1996).

3.5.5 Assessment of Trauma

Traumatic Experience Checklist (Nijenhuis, Van der Hart, & Kruger, 2002)

The Traumatic Experience Checklist (TEC) is a valid and reliable self-report questionnaire that measures traumatic experiences (Appendix 8). The TEC's internal consistency and test-retest reliability was very good with a Cronbach's α ranging from 0.85 to 0.90 (Nijenhuis et al., 2002; van Duijl et al, 2010). The test-retest reliability of the TEC total score was r = 0.91 (Nijenhuis et al., 2002).

The TEC consists of 29 types of potentially traumatic events. Participants are asked to rate potentially traumatising experiences on a 5-point Likert scale, from *none* (0) to *an extreme amount* (5). The TEC total score ranges from 0 to 29, and measures the subjective degree of anxiety associated with the trauma (Nijenhuis et al., 2002). Different scores can be calculated including a cumulative score, as well as separate scores for emotional neglect, emotional abuse, physical abuse, sexual harassment, sexual abuse, and bodily threat from a person. With respect to the above trauma areas, the TEC addresses the setting in which the traumatic experience occurred (Nijenhuis et al., 2002).

The TEC also calculates severity scores for each area of trauma by including four variables: a) the presence of the event; b) age of onset of traumatic experience; c) duration of the traumatic experience; and d) the participant's subjective response on the extent to which he or she felt affected by the trauma (Nijenhuis et al., 2002). These variables can be scored 1 if they apply, or 0 if they don't. Given that the TEC provides a comprehensive assessment of traumatic experiences, including specific areas of trauma, it was considered appropriate for this study. The structure of the questionnaire will allow the researcher to examine the contribution of each area of trauma in psychopathy and sadism. The questionnaire has also been used in previous studies with psychopathic patients (Craparo et al., 2013; Schimmenti et al., 2015).

3.5.6 Assessment of Narcissism

Narcissistic Personality Inventory 16 (NPI-16; Ames, Rose, & Anderson, 2006)

The Narcissistic Personality Inventory 16 (NPI-16) is the shortened version of the Narcissistic Personality Inventory -40 (Raskin & Terry, 1988), and is the most widely used measure of subclinical narcissism (Appendix 11). It draws its items from the NPI-40; however, the NPI-16 is preferred in situations which do not allow the use of longer measures. The NPI-16 is comprised of 16 sets of statements, and the participant is asked to choose one statement from each pair. As the authors state, the NPI-16 presents good predictive, discriminant and internal validity displaying a Cronbach's α=.72 (Ames, Rose, & Anderson, 2006). Considering the practical difficulties of using a longer measure, the NPI-16 was chosen to measure narcissistic traits in the population of forensic mental health patients. The NPI-16 was chosen over other similar measures of narcissism, like the Pathological Narcissism Inventory (PNI; Pincus et al., 2009), or the B – PNI (Schoenleber et al., 2015), as

it is shorter, requires less time to complete and it is more straight forward. Furthermore, the aim of introducing a measure for narcissism to this study was to test the presence of narcissistic core traits and not to examine the presence of pathological narcissism within the constructs of psychopathy and sexual sadism. Therefore, the NPI-16 was considered as appropriate measure in accordance with the aims and hypotheses of this study.

3.6 Semi-structured Interviews

Overview

The combination of the aforementioned measures for the assessment of sexual sadism (DSM V, ICD-10 and SESAS), trait sadism (ASP), trait narcissism (NPI-16), attachment insecurity and trauma (RAAS, RSQ and TEC) can considerably increase the diagnostic accuracy and reliability of the study through their predictive validity and reliability. However, they do not provide in-depth and detailed information about the participants' subjective experiences and their mental representations. Furthermore, the assessment of psychopathy and sadism as a mode of relating to others requires interpersonal variables, which can be obtained in greater detail through a semi-structured interview (Appendix 14).

The qualitative interviews will facilitate the exploration of the function of violence in those both with and without significant sadistic traits, and identify the early developmental antecedents which are potentially associated with sadism and psychopathy through the subjective experience of each participant. Considering that lying, conning and manipulating are specific clinical features of psychopathic and sadistic patients, it is argued self-report methods, despite their reliability, can be insufficient to accurately measure a trait due to the low 'true positive' rate. For that reason, the individual interviews (combined with validated questionnaires and self-report measures) will contribute to a better and deeper understanding of the psychopathic and sadistic personality.

Semi-structured Interviews

As described earlier in this chapter, those 12 participants, who were diagnosed with psychopathy, with the highest and lowest scores on the Assessment of Sadistic Personality (ASP) were approached for a semi-structured interview. Participant selection was based on the *a priory thematic saturation model* (Saunders et al., 2017) in which 'data is collected so as to exemplify theory, at the level of lower-order codes or themes, rather than to develop or refine theory' (Saunders et al., 2017, p. 4). Twenty-four patients were invited to participate; however, only 18 of them agreed to take part in the second phase of the study.

The semi-structured interview was comprised of three parts. In the first part the participants were asked to answer questions regarding their early relationships with their primary care givers. The second part involved questions in relation to the function of aggression; and the third addressed the significance of certain characteristics of the victim that may have triggered the participant's aggression. The interview narratives were analysed by means of *Thematic Analysis* which 'is a method for identifying, analysing, and reporting patterns (themes) within data' (Braun & Clarke, 2006, p. 6). To minimise the possibility of biased interpretation of the data, the researcher adhered to following the principles of thematic analysis described by Braun and Clarke (2006): 1) familiarising yourself with your data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes and, 6) producing the report. Consistent with Braun & Clarke's (2006) view that thematic analysis is not eliminated by any pre-existing model of interpretation, data for this study were interpreted using the Object relations theory as the theoretical model.

Object relations theory

Object relations theory is a whole strand of psychoanalytic theory that posits that interpersonal behaviour is the outcome of internalised, unconscious representation of oneself and others (Hinshelwood, 1991). The object-relations school includes various theoretical points of view; however, they all explain how the early interpersonal relationship with the primary caregivers constructs an internal psychological structure that serves as a foundation of future relationships.

This theory has been clinically proven to be relevant to psychopathic and sadistic patients. Several theorists have attempted to describe the quality of a psychopath's and sadist's early object relations (e.g., Gacano & Meloy, 1994; Kernberg, 1975, 1980, 1992; Meloy, 1988, 2001). For example, Kernberg (1980) suggested that psychopathic and sadistic object relations are marked by an absolute incapacity to experience feelings of guilt and non-exploitative relationships. Meloy (2002) and Juni (2010) have suggested that a psychopath's and sadist's internal world is dominated by severe aggression and basic distrust of others. Very few studies, however, empirically assess the object relations in psychopathic and sadistic patients (Gacano and Meloy, 1994; Brody & Rosenfeld, 2002).

3.7 Ethical Approval

This is a research project involving forensic mental health patients and prisoners within the National Health and Prison System and it has been reviewed and approved by both the East Midlands - Leicester South Research Ethics Committee (REC Reference: 17/EM/0282) and the Health Research Authority (HRA) on 22/8/2017 (Appendix 6), as well as the National Offender Management Service (NOMS). The ethical approval has been obtained on the basis described in the application form, protocol and supporting documentation which included a description of the participant selection criteria, study procedures and methods of recruitment (Appendix 1). Participants' rights were protected

throughout the study, and they were not exposed in any form of either physical or psychological harm. The research participants were informed at the time of entering the study that reporting of criminal or other disclosures made to the researcher was mandatory and the researcher had to relay such information to medical or prison staff. All identifying information was pseudonymised and no personal data were collected, apart from the consent forms, which have been stored in a secure cabinet within a locked area in the Centre for Psychiatry, Queen Mary University of London.

3.8 Data analyses

Quantitative study component

To test the hypotheses of this study, relationships between seven measures, namely the *Revised Adult Attachment Scale* (RASS), *Severe Sexual Sadism Scale* (SESAS), *Assessment of Sadistic Personality* (ASP), *Narcissistic Personality Inventory-16* (NPI-16), *Relationship Scale Questionnaire* (RSQ), the *Traumatic Experience Checklist* (TEC), and the *Psychopathy Checklist Revised* (PCL-R) were explored through a series of multiple linear regressions.

Apropos of the first objective, the relationships between sexual sadism, trait sadism and psychopathy were examined. In this objective, the *Severe Sexual Sadism Scale* (SESAS), the *Assessment of Sadistic Personality* (ASP) and their interaction were predictor variables and the *Psychopathy Checklist Revised* (PCL-R) was the dependent variable. The main effect of SESAS, the main effect of ASP, their interaction effect and their overall effect will all be used to predict psychopathy (PCL-R).

Following the next objective of the study, the effect of attachment abnormalities and sexual sadism, psychopathy and trait sadism were examined. For this objective, the RAAS, the RSQ, and their interaction were used as predictor variables in three linear regression

equations: one with the SESAS as the dependent variable, one with the PCL-R as a dependent variable, and one with the ASP as the dependent variable. The main effect of RAAS, the main effect of RSQ, their interaction effect and their omnibus effect were all tested on the SESAS, the PCL-R and the ASP.

In the third objective of the study, the relationship between psychopathy, trait sadism, sexual sadism and adverse childhood experiences were explored. This research question uses the SESAS, the ASP, the PCL-R, and their interaction as predictors in a linear regression equation with TEC as a dependent variable. The main effect of SESAS, the main effect of PCL-R, their interaction effect and their overall effect have all been tested to predict the presence of adverse childhood experiences.

To meet the last objective of the study, namely the relationships between psychopathy, sexual sadism, trait sadism and trait narcissism, the PCL-R, the SESAS, the ASP and their interaction were the predictor variables and the NPI-16 was the outcome variable. The main effect of PCL-R, the main effect of ASP and SESAS, their interaction effect and their overall effect will all be tested to predict narcissism (NPI-16).

Qualitative part of the study

For the *qualitative* part of the study, 18 participants were selected based on a review of the previous qualitative studies of the same nature. In this phase of the study, those 9 participants, who met the cut-off point for psychopathy, with the highest and lowest scores on the *Assessment of Sadistic Personality* (ASP), were approached for a semi-structured interview, to a total of 18 interviews. As mentioned earlier, data were analysed by means of thematic analysis and several key themes were identified. The themes were analysed using the object relations school of thought as a theoretical framework.

CHAPTER 4

RESULTS: QUANTITATIVE DATA

4.1 Psychopathy and Sexual Sadism

4.1.2 Frequencies

Frequencies were analysed for the type of offence, classification of the patient, ethnicity and age. With the sample of 59 male participants, 56 (94.9%) were White and 3 (5.1%) were other. Within this sample, 41 participants (69.5%) were classified as violent, and 18 (30.5%) as sexually violent (Table 1). With regard to the type of offence they had been convicted for, 24 (40.7%) participants had been convicted for grievous bodily harm; 12 (20.3%) for common assault; 4 (6.8%) for homicide; 7 (11.9%) for rape; 6 (10.2%) for sexual assault; and 6 (10.2%) for gun and knife crime (Table 1). Frequencies for psychopathy diagnosis revealed that 29 (49.2%) of the participants were identified as psychopathic having a score on the Psychopathy Checklist Revised (PCL-R) equal to or greater than 25, whereas 30 (50.8%) of the participants were classified as non-psychopaths (PCL-R < 25). Frequencies were also analysed for sexual sadism diagnosis and showed that 15 (25.4%) of the participants classified as sexual sadists having a score on the Severe Sexual Sadism Scale (SESAS) equal to or greater that 4 (SESAS > 4) in contrast to 44 (74.6%) who were not sexual sadists (SESAS < 4) (Table 1). All participants were native English speakers.

Table 1:

Frequencies for ethnicity, type of offence, classification of the patient and age (N=59)

Variable	Frequency	Percentage
Ethnicity		
White	56	94.9 %
Other	3	5.1 %
Classification	24	
Violent	*41*	69.5 %
Sexually violent	18	30.5%
Type of offence		
Grievous bodily harm	24	40.7 %
Common assault	12	20.3%
Rape	7	11.9 %
Gun and knife crime	6	10.2 %
Sexual assault	6	10.2 %
Homicide	4	6.8 %
Psychopathy diagnosis		
Psychopaths	29	49.2 %
Non-psychopaths	30	50.8 %
Sexual sadism diagnosis		
Sexual sadists	15	25.4 %
Non-sexual sadists	**44**	**74.6 %**

4.1.3 Descriptives

Descriptive statistics were initially run for the interval-ratio level variable of age (Table 2). The analysis showed that the minimum age was 22 years and the maximum was 65 years, with a mean age of 41.01 years (SD=10.30). Descriptive statistics were also run for the following dimensions: PCL-R; SESAS; and ASP. Psychopathy scores ranged from 8 to 33, with a mean score of 22.66 (SD=5.85), whereas scores on the SESAS ranged from 0-5, with a mean score of 1.10 (SD=1.78). The descriptive analysis further revealed that ASP scores ranged from 20-80, with a mean score of 32.12 (SD=10.27).

Table 2:

Descriptives for Age, PCL-R, SESAS and ASP (N=59)

Dimension	Range	Mean	Std.Dev.
Age	22-65	41.01	10.30
Psychopathy (PCL-R)	8-33	22.66	5.85
Sexual Sadism (SESAS)	0-5	1.10	1.78
Trait Sadism (ASP)	**20-80**	**32.12**	**10.27**

4.1.4 Reliability

First, means, standard deviations and internal consistency for the whole sample on each of the psychometrics were calculated. As seen in Table 3, internal consistency was acceptable for most questionnaire scales. The ASP demonstrated a Cronbach's alpha of .87

which indicates excellent internal reliability, strongly suggestive of a scale measuring a single underlying trait. The SESAS, however, demonstrated a negative Cronbach's alpha of -.78. That finding suggests that caution is warranted in interpreting relationships using the behavioural scale, as participants do not appear to be responding similarly to items within the scale, which was expected as not all participants are sexually violent, therefore SESAS was not applicable to everyone.

As mentioned in the previous chapter, the assessment of psychopathy was based on the existing, clinician-rated classification criteria of all four facets of the Psychopathy Checklist-Revised (PCL-R; Hare, 1993, 2000) and/or Psychopathy Checklist: Screening Version (PCL:SV; Hart, Cox and Hare, 1995). Participants' medical information, however, reflected only the total PCL-R score without illustrating the facets scores. It has not, therefore, been possible to use Cronbach's alpha to assess the reliability of the PCL-R. Nevertheless, research has shown that PCL-R is the internationally accepted gold-standard instrument for the assessment of psychopathy due to the consistency, reliability and validity that it displays (Hare & Neumann, 2008). Previous research has demonstrated that PCL-R items' internal reliability across six samples is 0.88; and there is internal consistency across 11 samples at $\alpha = 0.87$ (Shine & Hobson, 1997).

Table 3:

Raw score means, standard deviations, and internal consistency of PCL-R, ASP and SESAS (N=59)

Measure (possible range)	Mean	Std.Dev	Cronbach α
PCL-R (0-40)	22.66	5.85	
SESAS (0-11)	1.10	1.78	-.78
ASP	32.12	32.12	.87

4.1.5 Bivariate Analysis

Associations between key variables

At the first stage of analysis, Pearson correlations coefficients were calculated for the PCL-R, SESAS, and ASP to determine the empirical relationship between these variables. In accordance with the theoretical and clinical assumptions, significant positive correlations were found between psychopathy total scores and sexual sadism total scores (Table 4). Significant positive correlations were also found between the PCL-R total scores and the Assessment of Sadistic Personality (ASP) totals. These findings suggest that psychopathy is significantly associated with sexual sadism, as well as trait sadism. Surprisingly, however, trait sadism was not significantly correlated with sexual sadism.

Table 4:

Pearson Correlation Coefficients Between PCL-R, ASP and SESAS (N=59)

	PCL-R	SESAS
SESAS	.551**	
ASP	.281*	.204

*. *Correlation is significant at the 0.05 level (2-tailed).*

**. Correlation is significant at the 0.01 level (2-tailed).

Independent-Samples t-Tests

At the second stage of analysis, independent-samples t-tests were run across violent and sexually violent participants to check significant differences in psychopathy (Table 5). It was found that sexually violent participants were significantly more psychopathic compared (M= 27.28, SD=3.32) to the violent ones (M=20.63, SD=5.59); t (57) = -4.67, p=.019. This finding indicates that sexual violence is strongly associated with higher psychopathy scores.

Next, independent-samples t-test were run to test the underlying differences in psychopathy scores between sadistic and non-sadistic participants. In accordance with the hypothesis of the study, sexual sadists were found to be significantly more psychopathic (M=28.40, SD= 2.23) than the non-sexual sadists (M=20.70, SD= 5.41); t (57)= 5.33, p=.005. This is not surprising, and it confirms the findings of previous studies that reported significant associations between sexual sadism and psychopathy.

Table 5:

T-scores means and standard deviations in PCL-R between violent/sexually violent and sexually sadistic/non-sexually sadistic participants (N=59)

	Violent		**Sexually violent**		**Sexual sadists**		**Non-sexual sadists**	
PCL-R	**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**
	20.63	5.59	27.28	3.32	28.40	2.23	20.70	5.41

4.1.6 Regression analysis

To further test the hypothesis that sadism is associated with psychopathy, a multiple regression was employed to test the relationship between psychopathy, trait sadism and sexual sadism in violent and sexually violent participants. As mentioned above (see Table 5) significant positive correlations were found between the PCL-R total score, the SESAS and the ASP. Sexually violent participants were found to be significantly more psychopathic compared to non-sexual sadists. Similarly, sexually sadistic participants were considerably more psychopathic then their non-sexually sadistic inmates (see Table 5).

For this regression analysis, SESAS and ASP total scores acted as the independent variables, whereas PCL-R was the dependent variable. The main effect of SESAS, the main effect of ASP, their interaction effect and their overall effect were used to predict psychopathy (PCL-R). Trait sadism (ASP total) was entered at the last stage of the regression equation, after the first predictor variable, namely SESAS, was entered. The method of

entering trait sadism (ASP) as the last predictor variable was to examine the contribution of trait sadism in predicting psychopathy above and beyond the other predictors.

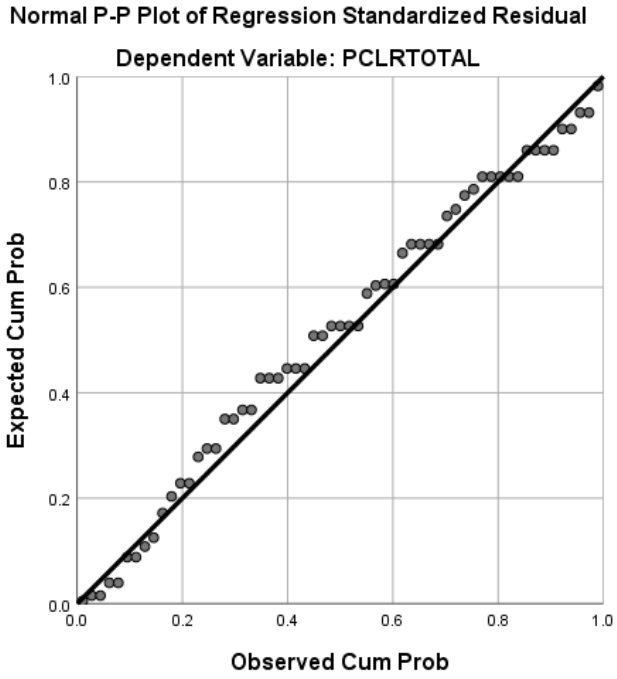
Prior to the regression analysis, the normality of the distribution of the dependent variable (PCL-R) was initially graphically examined for both violent and sexually violent participants by visually inspecting histograms, box plots and normal Q-Q Plots. A visual inspection of box plots, normal Q-Q plots and histograms showed that PCL-R scores were approximately normally distributed for both violent and sexually violent participants. PCL-R skewness and kurtosis for violent participants were -.481 and -0.452 respectively, whereas for sexually violent ones, they were -0.523 and 0.536 respectively. All four values for the 2 groups were within + /- 1.96, a finding that indicates that data were approximately normally distributed.

Next the normality of the distribution of the dependent variables was examined using the Shapiro-Wilk Test. The p value of the Shapiro-Wilk Test for the PCL-R for violent participants was .202, whereas for sexually violent, it was .762, confirming that the data for the PCL-R were approximately normally distributed.

In this regression analysis, it was examined whether sexual sadism and trait sadism could predict psychopathy. The analysis showed that sexual sadism is a strong predictor of psychopathy, $\beta = .52$, $t(56) = 4{,}62$, $p < .001$. This finding indicates that psychopathy scores are increased by 1.7 for every 1-unit increase in SESAS. Trait sadism, however, was not found to be a significant predictor of psychopathy ($\beta = .18$, $t(56)$, $p = .121$. It was found that the model explains approximately 30% of the variance in the data ($R2 = .33$, $F(2, 56) = 10.01$, $p < .001$). The Durbin-Watson $d = 2.077$, which is between the two critical values of $1.5 < d < 2.5$. In the final step of this regression model, normality of residuals was checked

with a normal P-P plot. The plot showed that the points do not show much deviation from the normal (diagonal) line, indicating that the residuals are normally distributed (Figure 1).

Figure 2



4.2 Psychopathy, sadism and early relational trauma

4.2.1. Frequencies and Descriptives

All 59 participants reported having had at least one traumatic experience during their life. Specifically, 91.5% reported at least one experience of emotional neglect; 82.4% emotional abuse; 96.6% bodily threat; 48.5% sexual harassment; and 44.2% sexual abuse. All participants had experienced more than one type of abuse (Table 6).

Descriptive statistics were calculated for PCL-R, ASP, SESAS and TEC (Table 6). PCL-R scores ranged from 8 to 33, with a mean score of 22.66 (SD=5.85). Scores on SESAS ranged from 0-5, with a mean score of 1.10 (SD=1.78). The descriptive analysis further revealed that scores ASP ranged from 20-80, with a mean score of 32.12 (SD=10.27). TEC scores ranged from 4 to 27, with a mean score of 15.34 (SD=5.34). Different TEC scores were calculated including a cumulative score, as well as scores for emotional neglect, emotional abuse, physical abuse, sexual abuse, sexual harassment and bodily threat from a person.

Table 6:

Descriptives for Age, PCL-R, TEC, SESAS and ASP (N=59)

Dimension	Range	Mean	SD
Age	22-65	41.01	10.30
Psychopathy (PCL-R)	8-33	22.66	5.85
Trauma (TEC)	4-27	15.34	5.34
Sexual Sadism (SESAS)	0-5	1.10	1.78
Trait Sadism (ASP)	**20-80**	**32.12**	**10.27**

4.2.2 Traumatic Experience Checklist's (TEC) Reliability

In order to assess the reliability of the TEC, the TEC trauma area scores, and Cronbach's a were calculated. The TEC demonstrated a Cronbach's alpha of .82 which indicates an excellent internal reliability, strongly suggestive of a scale measuring a single underlying trait. It also suggests that the items have relatively high internal consistency.

It was found that the first two TEC sub-scales (Emotional Neglect, Emotional Abuse) displayed acceptable reliability, with Cronbach alpha .69 for Emotional Neglect and .72 for Emotional Abuse. The third subscale (Bodily Threat) displayed poor internal reliability with an alpha score of .65. The two underlying TEC scales that reflect sexually traumatic experiences, however, also presented poor internal reliability, with Cronbach's alpha of .58 for Sexual Harassment and .50 for Sexual Abuse, which is lower than the acceptable threshold of .70. This finding suggests that TEC should be interpreted with caution.

Table 7:

Raw score means, standard deviations, and internal consistency of TEC and TEC subscales (N=59)

Measure (possible range)	**Mean**	**SD**	**α**
TEC	*0-29*	15.34	.82
Emotional Neglect	0-12	3.89	.69
Emotional Abuse	0-12	4.38	.72
Bodily threat	0-21	6.30	.65
Sexual Harassment	0-12	3.88	.58
Sexual Abuse	**0-12**	**3.53**	**.50**

4.2.3 Bivariate Analysis

Associations between key variables

At the first stage of the analysis, Pearson correlations were analysed between the TEC total, TEC scales and the measures of psychopathy (PCL-R), sexual sadism (SESAS) and trait sadism (ASP). It was found that both psychopathy (PCL-R) and sexual sadism (SESAS) were positively correlated with trauma (TEC) at a 0.05 level. This is not surprising considering that the three constructs have long been theoretically and clinically associated. Similarly, it is unsurprising that sexual sadism (SESAS) was significantly correlated with TEC scales that reflect sexual trauma, namely the 'sexual abuse' and 'sexual harassment scale'. Sexual sadism was negatively but not significantly correlated with the TEC 'emotional abuse scale'. Although, psychopathy was significantly correlated with trauma, it is interesting that no significant correlation was found between TEC scales and PCL-R. A positive correlation was reported between psychopathy and all the TEC scales; this correlation, however, was not found to be significant. Sadistic traits did not display any association with the TEC and its scales. This suggests that trauma is mainly associated with more severe forms of sadism, and particularly with sexual sadism as a categorical diagnosis, but not with sadistic traits and behaviours. Trait sadism was found to be negatively correlated with Sexual Harassment and Sexual Abuse TEC scales.

Table 8:

Pearson correlations coefficients between TEC, TEC subscales, PCL-R, SESAS and ASP (N=59)

	TEC total score	TEC Sexual Abuse	TEC Emotional Neglect	TEC Emotional Abuse	TEC Bodily Threat	TEC Sexual Harassment
PCL-R	*.304**	*.153*	*.225*	*.041*	*.072*	*.110*
SESAS	*.267**	*.366***	*.189*	*-.012*	*.228*	*.312**
ASP	*.124*	*-.027*	*.226*	*.059*	*0.46*	*-.056*

Correlation is significant at the 0.05 level (2-tailed).*
Correlation is significant at the 0.01 level (2-tailed).**

Trauma differences among groups of participants

At the second stage of analysis, a series of independent-samples t-tests were performed to examine the differences in levels of trauma in the following groups of participants: psychopaths and non-psychopaths, sexual sadists and non-sexual sadists, sadistic psychopaths and non-sadistic psychopaths.

First the study examined the differences in traumatic experiences between violent and sexually violent participants. It was found that sexually violent participants scored considerably higher on TEC, reporting a mean score of 17.39 (SD = 6.97), compared to violent participants whose mean score was 14.44 (SD= 4.24); t (57) = -2.00, p= .001.) Then the differences in mean scores for the TEC scales were examined in the same group of participants. It was found that sexually violent patients reported significantly higher mean on the TEC Bodily Threat Scale (M=15.78, SD=6.50), compared to violent (M=12.00, SD=5.93) t (57) = -2.18, p=.033). Similarly, sexually violent patients scored significantly higher than

the violent on the TEC Sexual Harassment (M = 4.89, SD = 4.45/ M = 2.24, SD = 3.35 respectively; t (57)=-2.51, p =.015); and on the TEC Sexual Abuse scale (M = 4.67, SD = 3.94, M = 2.24, SD = 3.10, respectively); t (57) = 2.53, p = .014). These findings suggest that sexual violence is strongly related to sexually traumatic experiences.

Next, the differences in levels of trauma were examined between psychopathic and non-psychopathic participants. Psychopathic participants scored significantly higher on TEC (M = 17.55, SD = 5.35) compared to their non-psychopathic inmates (M = 13.20, SD = 4.45); t (57) = 3.39, p = .001). This confirms a primary hypothesis of this thesis that exposure to trauma during early childhood is associated with the development of more psychopathic traits. Then the relationship between psychopathy and specific types of trauma was examined. It was found that psychopaths presented significantly higher means only on the TEC Emotional Neglect scale than the non-psychopaths (M = 10.48, SD = 3.10 / M = 8.13, SD = 4.26); t (57) = 2.41, p = .019). It is noted that psychopaths presented higher scores in all other areas of trauma; however, the differences were not significant.

The study next examined differences in trauma between sexual and non-sexual sadists. Sexual sadists reported higher scores on TEC (M=17.60, SD=7.35), in comparison to non-sexual sadists (M=14.57, SD=4.30); t (57) = 1.94, p=.057) but those differences were not significant. This finding rejects one of the primary hypotheses of the study that adverse experiences will be associated with sexual sadism. Sexual sadists, however presented significantly higher mean scores on the TEC Sexual Harassment scale (M=4.80, SD=4.58/ M=2.45, SD=3.47, respectively) t (57) = 2.07, p=.042; and on the TEC Sexual Abuse scale (M= 4.80, SD=4.32/ M= 2.36, SD=3.02; t (57) = 2.40, p = .020). That finding may suggest a link between sexual abuse and the development of sexual sadism.

Finally, a series of t-tests were performed to test the differences in trauma between sadistic and non-sadistic psychopaths. No significant differences were found in the mean trauma scores between sadistic and non-sadistic psychopaths. Sadistic psychopaths, however, reported significantly higher scores on the TEC Sexual Abuse scale (M=5.14, SD=4.27), compared to non-sadistic psychopaths (M=2.00, SD=2.53); $t(28) = 2.48$, $p = .019$). No significant differences were reported between the rest of the TEC scales between these groups. This finding confirms the hypothesis that sadistic psychopaths will present higher levels of early childhood trauma compared to non-sadistic psychopaths; however, these traumatic experiences were specifically related to sexual abuse and harassment.

Table 9:
T-scores means and standard deviations in TEC and TEC subscales between violent/sexually violent and sexually sadistic/non-sexually sadistic participants (N=59)

	Violent		**Sexually violent**		**Psychopathic**		**Non-psychopathic**		**Sadistic**		**Non-sadistic**	
Total TEC score	**Mean**	**Std. Dev.**	**Mean**	**Std. Daev**	**Mean**	**Std. Dev**	**Mean**	**Std. Dev**	**Mean**	**Std. Dev**	**Mean**	**Std. Dev**
Emotional Neglect	*8.88*	*3.95*	*10.22*	*3.68*	*10.48*	*3.10*	*8.13*	*4.26*	*9.87*	*3.96*	*9.09*	*3.89*
Emotional Abuse	*8.59*	*3.10*	*7.56*	*3.94*	*9.24*	*4.10*	*7.33*	*4.58*	*8.80*	*4.05*	*8.09*	*4.52*
Bodily Threat	*12.00*	*5.93*	*15.88*	*6.50*	*10.62*	*5.04*	*11.73*	*7.11*	*1.52*	*6.08*	*1.24*	*6.29*
Sexual Harassment	*2.24*	*3.35*	*4.89*	*4.45*	*3.72*	*4.26*	*2.40*	*3.42*	*4.80*	*4.58*	*2.45*	*3.47*
Sexual Abuse	*2.24*	*3.10*	*4.67*	*3.94*	*3.59*	*3.75*	*2.40*	*3.25*	*9.09*	*4.05*	*4.80*	*4.52*

4.2.4. Regression Analysis

To further test the differences in the levels of trauma in the relationship between psychopathy, sexual sadism, and trait sadism, a series of regression analyses for each group of participants were run. As mentioned above (Table 4) significant positive correlations were found between the TEC and SESAS, as well as between the TEC and PCL-R. However, no statistically significant correlations were found been ASP and TEC. To explore the relationship between psychopathy, trait sadism and sexual sadism, the SESAS, the ASP, the PCL-R and their interaction were used as predictors in a linear regression equation with TEC as a dependent variable. The main effect of SESAS, the main effect of ASP, and the main effect of PCL-R, their interaction effect and their overall effect were all tested to predict the presence of adverse childhood experiences.

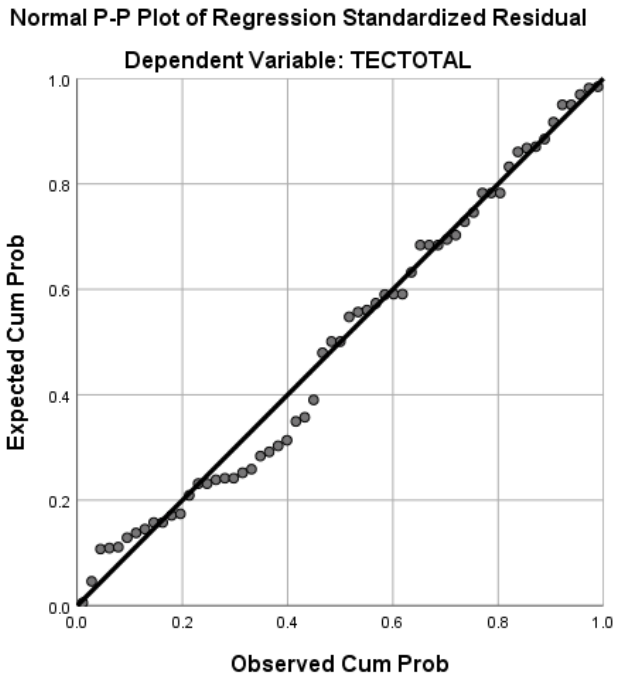
Prior to the regression analysis, the normality of the distribution of the dependent variable (TEC) was initially graphically examined for both violent and sexually violent participants by visually inspecting histograms, box plots and normal Q-Q Plots. A visual inspection of box plots, normal Q-Q plots and histograms showed that TEC scores were approximately normally distributed for both violent and sexually violent participants. TEC skewness and kurtosis for violent participants were -0.24 and -0.81 respectively, whereas for sexually violent ones, they were -0.37 and 1.05 respectively. All four values for the 2 groups were within + /- 1.96, a finding that indicates that data are approximately normally distributed. It is noted that the data are a little skewed and kurtotic for both violent and sexually violent participants.

Next, the normality of the distribution of the dependent variables was examined using the Shapiro-Wilk Test. The p value of the Shapiro-Wilk Test for violent participants was

.375, whereas for sexually violent, it was .331; therefore, it can be assumed that the data were approximately normally distributed.

In this regression analysis, it was examined whether sexual sadism, trait sadism and psychopathy could predict trauma. The analysis showed that trauma was a strong predictor of psychopathy (β= .30, t (57) = 2,40, p = .019). That finding indicates that those participants with higher psychopathy scores tend to report more traumatic experiences. That confirms a primary hypothesis of the study which suggested that exposure to trauma during early childhood is associated with the development of more severe psychopathic traits. It was found that the model explains approximately 92% of the variance in the data (R2 = .92, F (1, 57) = 5.794, p = .019). The Durbin-Watson d= 1.851, which is between the two critical values of $1.5 < d < 2.5$. In the final step of this regression model, normality of residuals was checked with a normal P-P plot. The plot showed that the points do not drastically deviate from the normal (diagonal) line, a finding that indicates that the residuals are normally distributed (Figure 2).

Figure 3


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: TECTOTAL
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

4.3 Attachment abnormalities in psychopathy and sexual sadism

4.3.1. Frequencies and Descriptives

Frequencies were analysed for each attachment style, first for the Revised Adult Attachment Scale (RAAS) and then for the Relationship Scale Questionnaire (RSQ). Considering RAAS's two broad categories, namely Attachment Avoidance and Attachment Anxiety, it was found that 71.1% percent of the participants scored higher than 2.5 being closer to the high end of the attachment anxiety scale, whereas 28.9% scored lower than 2.5 on the scale. 79.6% of the participants scored higher than 2.5 on the avoidance attachment scale, in contrast to 20.4% who scored relatively lower. Following the RAAS's three category model (Close, Depend, Anxiety), 88.1% scored closer to the end of the Close scale; 69.4% scored higher than 2.5 on the Depend scale; 71.1% scored lower to the high end of the scale on Anxiety. With regard to the RSQ. 86.4% scored close to the high end of the RSQ Secure scale; 79.6 scored close to the high end of the RSQ fearful scale; 74.5 higher than 2.5 on the Preoccupied scale; and 86.4 scored higher than 2.5.

Descriptive statistics were run for RSQ and RAAS scales as well. Attachment Anxiety scores ranged from 1.83 to 4.5, with a mean of 3.07 (SD=.680). Scores on the Attachment Avoidance scale ranged from 1.33 to 3.92, with a mean score of 2.90 (SD=.498). For the RSQ scales, scores on the Secure scale ranged from 1 to 4.2, with a mean of 2.95 (SD=.553); from 2 to 5, with a mean of 3.4 (SD=3.42) on the Fearful scale; scores for the Preoccupied scale ranged from 1.5 to 4.25, with a mean of 2.97 (SD=.614); and scores for the Dismissing scale from 2 to 4.60, with a mean of 3.24 (SD=.657).

Table 10:
Descriptives for RAAS and RSQ scales (N=59)

Dimension	Range	Mean	SD
RAAS			
Attachment Anxiety	1.83 - 4.5	3.07	0.68
Attachment Avoidance	1.33 - 3.92	2.90	0.49
RSQ	0 - 5	1.10	1.78
Secure	1 - 4.2	2.95	0.55
Fearful	2-5	3.42	0.81
Preoccupied	1.5 - 4.25	2.97	0.61
Dismissing	2.00 – 4.60	3.24	0.65

4.3.2 RAAS and RSQ Reliability

The RSQ demonstrated a Cronbach's alpha of .79 which indicates good internal reliability, strongly suggestive of a scale measuring a single underlying trait. It also suggests that the items have relatively high internal consistency. Next, reliability analysis was carried out for the four RSQ scales, namely the Secure, Fearful, Dismissing and Preoccupied scale. It was found that Cronbach's alpha for the Fearful RSQ scale was .57.; -.083 for the Preoccupied scale; -.003 for the Secure scale; and .42 for the Dismissing scale. It is noted that the Cronbach's alpha score for all the RSQ subscales is considerably lower than the Cronbach's threshold.

The RAAS demonstrated a Cronbach's alpha of .57, which is considerably lower than the accepted threshold of >.70. This may suggest that there is poor interrelatedness between the scale's items. Next, a reliability analysis was carried out for the two RAAS subscales, namely Attachment Anxiety and Attachment Avoidance. It was found that Attachment Anxiety displayed relatively poor internal reliability, with an alpha score of .63. Similarly, Cronbach's a for the Attachment Avoidance Scale was .60 which also indicates poor internal reliability.

Table 11:
Internal consistency for RSQ, RAAS and their subscales (N=59)

Dimension	α
RAAS	.57
Attachment Anxiety	.63
Attachment Avoidance	.60
RSQ	.79
Secure	-.003
Fearful	.57
Preoccupied	-0.83
Dismissing	.42

4.3.3 Bivariate Analysis

Associations between key variables

At first stage of analysis, Pearson correlations were carried out between the RAAS and RSQ scales and the measures of psychopathy (PCL-R), sexual sadism (SESAS) and trait sadism (ASP). In contrast to the theoretical and clinical assumptions, no statistically significant correlation was found between psychopathy and attachment abnormalities. Psychopathy was found to be negatively but not significantly correlated with secure and avoidance attachment styles. Sexual Sadism was found to be significantly but negatively correlated with attachment avoidance at a 0.05 level. Sexual sadism was also found to be negatively but not significantly correlated with secure, avoidance, anxiety and fearful; and positively correlated with attachment avoidance. Similarly, no significant correlations between trait sadism and all the attachment abnormalities were found. Although not significantly associated, trait sadism was positively correlated with fearful and with secure attachment.

Table 12

Pearson correlations of RSQ and RAAS subscales with Psychopathy, Sexual Sadism and Trait Sadism (N=59)

	Attachment Anxiety	**RSQ Secure**	**RSQ Fearful**	**RSQ Preoccupied**	**RSQ Dismissing**	**Attachment Avoidance**
PCL-R	.011	-.207	.069	-.164	.101	-.199
SESAS	-.191	-.221	-.004	-.104	.231	-.274*
ASP	-.108	.118	.238	-.161	.090	-.088

*Correlation is significant at the 0.05 level (2-tailed).**

Independent-samples t – tests

At the second stage of analysis, a series of independent-samples t-tests were performed to examine the attachment styles in the following groups: violent and sexually violent; psychopaths and non-psychopaths; sexual sadists and non-sexual sadists; sadistic psychopaths and non-sadistic psychopaths.

First, the study examined the differences in attachment styles between violent and sexually violent participants (Table 13). It was found that there were no statistically significant differences in attachment orientations between violent and sexually violent participants. It is noted, however, that violent participants obtained higher scores in all attachment scales compared to the sexually violent ones.

Next, the analysis considered the differences in the attachment styles between psychopathic and non-psychopathic participants (Table 13). Surprisingly and in contrast to expectations, only a statistically significant negative association between secure attachment and psychopathy (M = 2.80, SD = .56); t (57) = .267, p = .036) was found. Non-psychopaths, however, scored higher on avoidance, preoccupied, secure and anxious, whereas psychopaths scored higher on the fearful scale.

Then, the differences between attachment orientations were examined in the group of sexually sadistic and non-sexually sadistic participants (Table 13). It was found that sexual sadists are statistically less avoidant (M=2.66, SD=.61) compared to non-sexual sadists (M = 2.98, SD = .42); t (57) = -2.26, p = .027), and also considerably less secure (M = 2.65, SD = .49 and M = 3.05, SD = .49 accordingly) t (57) = - 2.53, p = .014. It was also found that sexual sadists are significantly more dismissing (M = 3.57, SD = .62) compared to non-sexual sadists (M=3.13, SD=.63); t (57) = 2.30, p = .025. There were no statistically significant associations between the other attachment styles and sexual sadism found.

Finally, the differences in attachment styles between sadistic and non-sadistic psychopaths were explored (Table 13). Sadistic psychopaths presented statistically significant differences in the RSQ dismissing scale (M = 3.61, SD = .62), compared to non-sadistic psychopaths (M = 3.10, SD =.56); t (28) = 2.37, p = .025. Furthermore, sadistic psychopaths reported higher scores only on the preoccupied scale, whereas non-sadistic psychopaths reported higher scores for all the other attachment scales.

Table 13:
Differences in attachment styles between participant groups (N=59)

	Violent		**Sexually Violent**		**Psychopathic**		**Non-psychopathic**		**Sadistic**		**Non-sadistic**		**Sadistic Psychopaths**		**Non-sadistic Psychopaths**	
RAAS	Mean	S.D	Mean	S.D	Mean	S.D	Mean	S.D	Mean	S.D	Mean	S.D	Mean	S.D	Mean	S.D
Attachment Avoidance	2.98	.43	2.71	.58	2.78	.50	3.02	.46	3.96	.61	2.98	.47	2.64	.63	1.05	2.47
Attachment Anxiety	3.16	.66	2.87	.68	3.02	.74	3.11	.62	2.81	.72	3.16	.64	2.87	.68	3.10	.79
RSQ																
Preoccupied	3.03	.51	2.86	.80	2.89	.75	3.02	.46	2.88	.88	3.01	.50	2.94	.87	2.87	.639
Fearful	3.44	.83	3.38	.77	3.45	.82	3.40	.81	3.36	.78	3.44	.82	3.39	.80	3.43	.88
Secure	3.02	.48	2.78	.66	3.10	.50	3.02	.74	2.65	.62	3.05	.49	2.92	.44	2.92	.44
Dismissing	3.18	.62	3.38	.71	3.35	.64	3.14	.66	3.57	.62	3.13	.63	3.61	.62	3.10	.56

4.3.4. Regression Analysis

To further test the differences in the attachment styles in the relationship between psychopathy, sexual sadism, and trait sadism, a series of regression analyses for each group of participants were run. As mentioned above (Tables 12 & 13) significant correlations were found between sexual sadism and attachment avoidance (RAAS) as well as sexual sadism and dismissing attachment (RSQ). However, no statistically significant correlations were found been psychopathy and attachment abnormalities as well as between the latter and trait sadism.

In this regression analysis RAAS, the RSQ and their interaction were used as predictor variables in three linear regression equations: one with the SESAS as the dependent variable, one with the PCL-R as a dependent variable, and one with the ASP as the dependent variable. The main effect of RAAS, the main effect of RSQ, their interaction effect and their omnibus effect will all be tested on the SESAS, the PCL-R and the ASP.

Prior to the regression analysis, the level of normality of the distribution of the dependent variables (RAAS and RSQ scales) was initially graphically examined for both violent and sexually violent participants by visually inspecting histograms, box plots and normal Q-Q plots. The visual inspection of box plots, normal Q-Q plots and histograms showed that the RSQ Secure scale skewness and kurtosis for violent participants were -1.46 and 1.22 respectively, whereas for sexually violent participants, they were -1.85 and 2.17. RSQ Fearful scale skewness and kurtosis were 0.32 and -1.42, whereas for sexually violent participants, they were 0.85 respectively. RSQ Preoccupied scale skewness and kurtosis for violent participants were -0.80 and 0.99, whereas for sexually violent ones, they were 0.88

and -1.18 respectively. RSQ Dismissing scale skewness and kurtosis for violent participants were -0.21, whereas for sexually violent participants, they were -0.61 respectively.

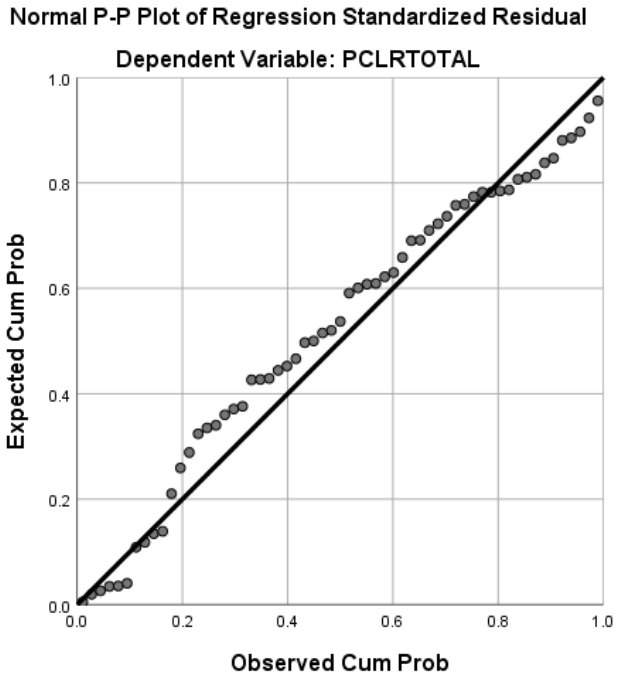
RAAS Attachment Anxiety scale skewness and kurtosis for violent participants were 0.60 and -0.98, whereas for sexually violent participants, they were 0.11 and -1.12 respectively. RAAS Attachment Avoidance scale skewness and kurtosis for violent participants were -2.43 and 5.84, whereas for sexually violent participants, they were -1.31 and 0.25 respectively. It is noted that all four values for the 2 groups were within + /- 1.96, (apart from RAAS Attachment Avoidance kurtosis for violent participants and RSQ Secure kurtosis for the sexually violent patients that slightly deviated from the + /- 1.96), a finding that indicates that data are approximately normally distributed.

Next, the normality of the distribution of the dependent variables was examined using the Shapiro-Wilk Test. The p value of the Shapiro-Wilk Test for violent participants was .021 (RSQ Secure); .123 (RSQ Fearful); .137 (RSQ Preoccupied); .537 (RSQ Dismissing); .227 (RAAS Attachment Anxiety); .003 (RAAS Attachment Avoidance), whereas the p value of the Shapiro-Wilk Test for sexually violent participants was .133 (RSQ Secure); .180 (RSQ Fearful); .052 (RSQ Preoccupied); . 617 (RSQ Dismissing); .155 (RAAS Attachment Anxiety); .423 (RAAS Attachment Avoidance). It is noted that all values are above .005, so the null hypothesis is accepted for all attachment scales apart from the RSQ Secure scale and RAAS Attachment Avoidance for violent participants. For the Shapiro-Wilk test, therefore, it can be assumed that the data are approximately normally distributed.

In this regression analysis, it was examined whether attachment abnormalities could predict psychopathy. For this reason, RAAS, the RSQ, and their interaction were used as predictor variables, whereas PCL-R was the dependent variable. Surprisingly and in contrast

to the hypotheses of this study, no association was found between attachment insecurity (RAAS, RSQ) and psychopathy. Indeed, attachment insecurity was not found to be a significant predictor of psychopathy (R2 = .08, F (0.78, 6) = 5.927, p = .702). The Durbin-Watson d= 1.744, which is between the two critical values of 1.5 < d < 2.5. In the final step of this regression model, normality of residuals was checked with a normal P-P plot. The plot showed that the points slightly deviate from the normal (diagonal).

Figure 4



The next linear regression equation aimed to explore the relationship between Sexual Sadism (SESAS) and Attachment orientations (RSQ, RAAS). In this linear regression equation, SESAS acted as the dependent variable and the RSQ and RAAS as the predictor variables.

Before running the regression analysis, the normality of the distribution of the dependent variable (SESAS) was initially graphically examined for both violent and sexually violent participants by visually inspecting histograms, box plots and normal Q-Q Plots. A visual inspection of box plots, normal Q-Q plots and histograms showed that SESAS scores were not normally distributed for both violent and sexually violent participants. Data were also found to be highly skewed and kurtotic, so the variables were not suitable for regression analysis.

Given that the data were not normally distributed, a non-parametric test was chosen as more appropriate. To test the hypothesis that attachments in both sexually sadistic and non-sexually sadistic participants will be more anxious, insecure and dismissing compared to non-psychopaths, the Mann-Whitney test was used. The Mann-Whitney test revealed that sexual sadists were significantly more dismissing comparing to non-sexual sadists ($p = .022$). That means that only RSQ Dismissing attachment was significantly related with sexual sadism. Similarly, both the Mann-Whitney test showed that sadistic psychopaths were more dismissing comparing to non-sadistic psychopaths ($p = .009$).

4.4 Narcissistic traits in psychopathy and sexual sadism

4.4.1. Frequencies and Descriptives

88.1 % of the participants had at least one narcissistic trait, whereas 11.9% reported no narcissistic traits at all. Next, descriptive statistics were run for the Narcissistic Personality Inventory – 16 (NPI – 16). For the 59 violent and sexually violent participants NPI scores were ranged from 0 to 10 (M= 4.51, SD= 2.61). Out of the 59, 28 participants (47.5%) reported between 5 and 7 narcissistic traits, whereas only 6 participants (10.2%) scored higher than 8 on the test. 7 participants (11.9%) reported no narcissistic traits, whereas 18 participants 30.6% reported from 1 to 4 narcissistic traits on NPI-16.

4.4.2 Narcissistic Personality Inventory (NPI-16) reliability

First, means, standard deviations and internal consistency of NPI-16 was calculated. As seen in Table 14, The NPI-16 demonstrated a Cronbach's alpha of .51 which indicates that 51% of the variability in a composite score by combining NPI's 16 items. That means that 51% of the variance score would be considered true score variance. It is noted, however, that NPI Cronbach's alpha of .51 is considerably lower than the accepted threshold of >.70. This may suggest that NPI-16 needs to be interpreted with caution.

4.4.3 Bivariate Analysis

Associations between key variables

At the first stage of analysis, Pearson correlations were calculated between the NPI-16 and the measures of psychopathy (PCL-R), sexual sadism (SESAS) and trait sadism (ASP). In contrast to the theoretical and clinical assumptions, no statistically significant correlation was found between narcissism, psychopathy and sexual sadism. Narcissism, however, was found to be positively correlated with trait sadism at a 0.05 level (Table 14).

Table 14:

Pearson Correlations of NPI-16 with Psychopathy, Sexual Sadism and Trait Sadism (N=59)

	PCL-R	SESAS	ASP
PCL-R			
SESAS	.551**		
ASP	.281*	.204	
NPI	.214	-.022	.358**

**. Correlation is significant at the 0.05 level (2-tailed).*

Independent-samples t – tests

At the second stage of analysis, a series of independent-samples t-tests were performed to examine the presence of narcissistic traits in the following groups: violent and sexually violent; psychopaths and non-psychopaths; sexual sadists and non-sexual sadists; and sadistic psychopaths and non-sadistic psychopaths.

First, the study examined the presence of narcissistic traits in violent and sexually violent participants (Table 15). It was found that there were no statistically significant differences in narcissism between violent and sexually violent participants. It is noted, however, that violent participants obtained higher scores on narcissism compared to the sexually violent ones (M=4.59 and M=4.33 respectively).

Next, the analysis explored the relationship between narcissism and psychopathy in psychopathic and non-psychopathic participants (Table 15). It was not surprising that psychopathy was found to be positively correlated with narcissism. Indeed, psychopaths were found to be significantly more narcissistic (M=5.28, SD=2.56) compared to non-psychopaths (M=3.77, SD=2.48); t (57) = 2.29, p = .025).

The presence of narcissistic traits was then examined in sexually sadistic and non-sadistic participants (Table 15). In contrast to expectations, no significant differences were reported in the mean NPI-16 scores between sexual sadists and non-sexual sadists. Although not significant, sexual sadists reported a slightly higher mean score on narcissism (M=4.73, SD=2.39), compared to non-sexual sadists (M=4.43, SD=2.52).

Finally, the differences in the mean score of narcissism were explored between sadistic and non-sadistic psychopaths (Table 15). It was hypothesised that sadistic psychopaths would be significantly more narcissistic compared to non-psychopaths. This, however, has not been confirmed as there were no significant differences found between the groups.

Table 15:

Differences in NPI mean scores for violent/sexually violent, sadistic/non-sadistic, psychopathic / non-psychopathic, as well as sadistic and non-sadistic psychopaths (N=59)

	Violent		**Sexually violent**		**Psychopathic**		**Non-psychopathic**		**Sadistic**		**Non-sadistic**		**Sadistic psychopaths**		**Non-sadistic psychopaths**	
NPI	**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**	**Mean**	**S.D**
	4.59	2.54	4.33	2.82	5.28	2.52	3.77	2.48	4.73	2.93	4.43	2.52	4.79	3.04	5.69	1.95

4.4.4. Regression Analysis

To further test the relationship between narcissism, psychopathy, sexual sadism, and trait sadism, a linear regression analysis was conducted. As mentioned above (Tables 14 and 15), significant positive correlations were found between narcissism (NPI) and trait sadism (ASP). However, statistically significant correlations were found neither between psychopathy nor between psychopathy and sexual sadism.

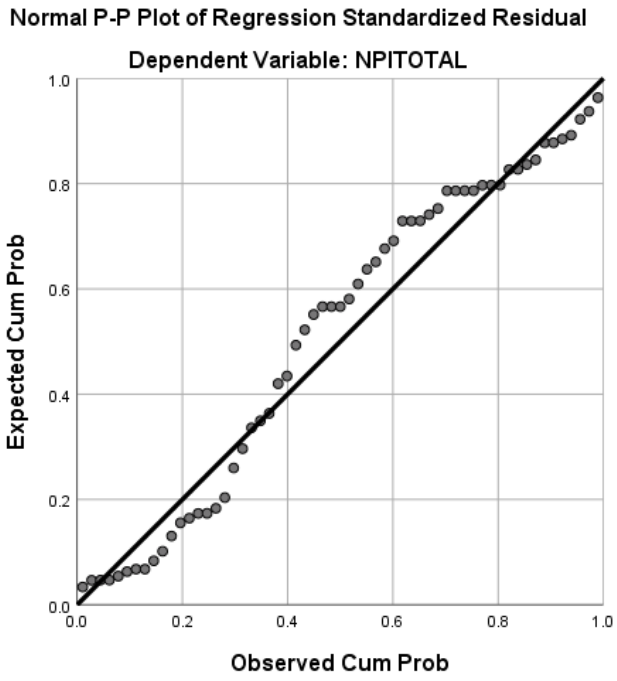
In this regression analysis, RAAS, the PCL-R, the SESAS, the ASP and their interaction were the predictor variables and NPI-16 was the outcome variable. The main effect of PCL-R, the main effect of ASP and SESAS, their interaction effect and their overall effect were all tested to predict narcissism (NPI-16).

Prior to the regression analysis, the normality of the distribution of the dependent variable (NPI) was initially graphically examined for both violent and sexually violent participants by visually inspecting histograms, box plots and normal Q-Q Plots. A visual inspection of box plots, normal Q-Q plots and histograms showed that NPI scores were approximately normally distributed for both violent and sexually violent participants. NPI skewness and kurtosis for violent participants were -0.84 and -0.64, whereas for sexually violent ones, they were -0.23 and 1.17 respectively. All four values for the 2 groups were within + /- 1.96, a finding that indicates that data are approximately normally distributed.

In this regression analysis, whether narcissism sexual sadism, trait sadism and psychopathy could predict narcissism was examined. In this regression analysis, the NPI was the dependent variable, whereas SESAS, PCL-R and ASP were the independent variables.

Narcissism was not found to be a strong predictor of either sexual sadism or psychopathy. The analysis showed, however, that only trait sadism was useful for predicting narcissism. That means that with all the variables entered into the regression model, only ASP remained a significant predictor of NPI-16, $\beta = .35$, $t(57) = 2.89$, $p = .005$. It was found that the model explains approximately 12% of the variance in the data ($R2 = .12$, $F(1, 57) = 2.464$, $p < .005$). The Durbin-Watson $d = 1.604$, which is between the two critical values of $1.5 < d < 2.5$. In the final step of this regression model, normality of residuals was checked with a normal P-P plot. The plot showed that the points do not drastically deviate from the normal (diagonal). This indicates that the residuals are not normally distributed.

Figure 5


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: NPITOTAL
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

CHAPTER 5

RESULTS: QUALITATIVE

5.1 Overview

The findings from the forensic patient semi-structured qualitative interviews will be presented and analysed in this section. As was mentioned in Chapter 3, 18 participants, who were diagnosed with psychopathy and those with the highest and lowest scores on the Assessment of Sadistic Personality (ASP) were invited to take part in this phase of the study. All participants who were approached then consented to be involved. Among the participants, the highest score on ASP was 50 and the lowest was 21. Given that most of the participants scored relatively low on the ASP scale, a score equal to or greater than 35 was used as the cut-off point to differentiate the sadistic from the non-sadistic psychopaths. From the total sample of 18 patients, 8 of them were identified as sadistic-psychopaths (ASP $\geq$ 35) and 10 as non-sadistic (ASP < 35).

Overall, 5 out of 8 psychopathic patients who scored higher on the ASP were also classified as sexual sadists (SESAS $\geq$ 4), whereas only 3 of those who scored lower on ASP classified as sexual sadists. Within the group of sadistic psychopaths, 5 of them were convicted for sexual crimes (including rape, attempted rape or child molesting; and 3 of them for grievous bodily harm). The minimum PCL-R score was 25 and the maximum 31, whereas the minimum ASP score was 39 and the maximum 50. Within the group of non-sadistic psychopaths, 3 of them were convicted for sexual crimes; and 7 for other violent offences (including murder, GBH and kidnap). In the same group of participants, the minimum PCL-R score was 25 and the maximum 33, whereas the

maximum score on ASP was 34 and the minimum 21. A summary of the demographic data for participants is detailed in Table 16.

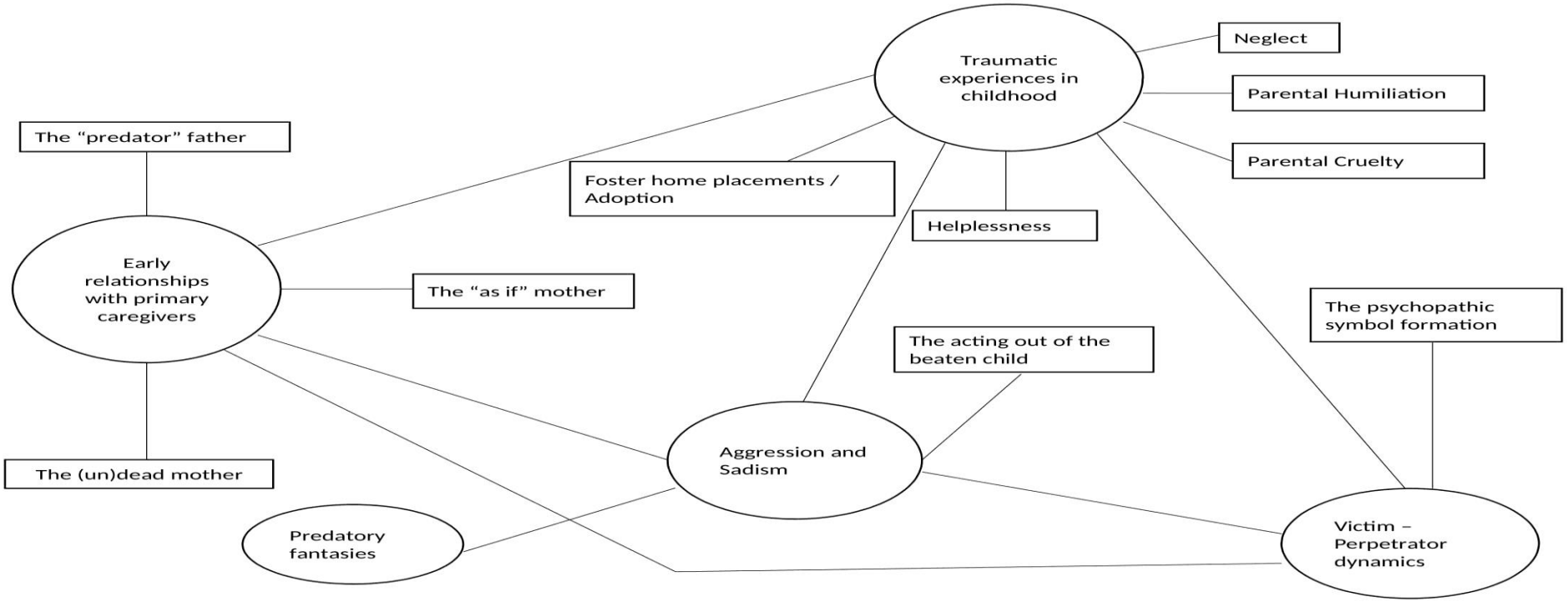
Table 16: Demographic data for the patient interviews for sadistic and non-sadistic psychopaths (N=18)					
ID	**Age Group**	**Type of Offence**	**PCL-R total**	**ASP total**	**Evidence of sexual sadism**
CLLSH36	36-45	Violent	26	27	no
CLCBV53	46-55	Sexually Violent	25	26	yes
MEIGV64	56-65	Sexually Violent	31	23	yes
MEIGF53	46-55	Sexually Violent	27	39	yes
CLBOW38	36-45	Violent	28	45	yes
MEICR35	18-35	Violent	25	32	no
CLAVG47	46-55	Violent	27	41	no
CLANC39	36-45	Violent	25	34	no
CLDOO49	46-55	Sexually Violent	31	50	yes
CLDEC49	46-55	Violent	26	21	no
CLERQ31	18-35	Violent	27	32	no
CLDWG54	46-55	Violent	33	25	yes
MEIIV31	18-35	Violent	27	28	no
MEIFR52	46-55	Violent	25	39	no
CLCCO38	36-45	Violent	27	41	yes
CLBKO39	36-45	Sexually Violent	31	39	yes
CLERQ31	18-35	Violent	27	32	no
CLEJA29	18-35	Sexually Violent	25	38	no

5.2 Themes from Patient Interviews

Using the principles of Thematic Analysis, five main themes and several sub-themes were identified. These are presented in Figure 6. The five themes emerged

across all of the data set and were highly salient for most sadistic and non-sadistic psychopathic patients. Some of these themes were more evident in some accounts than others.

Figure 6: Thematic Map, showing the five main themes



Theme 1: Early relationships with primary care givers

The '(Un)dead Mother'

The sub-theme of the (un)dead mother was identified in 14 out of 18 participants. The name of the theme reflects a combination of André Green's (1986) 'dead mother complex', which refers to the picture of an emotionally detached and withdrawn mother that creates a narcissistic wound in the child's psyche; and Christina Wieland's (2002) notion of the 'Undead Mother' that refers to the symbolic murder of someone's feminine side that leads to dis-identification and violent separation from the goodness of the internal mother. The 'deadness' of the mother, as presented in the patients' narratives, appeared to lead to the formation of a sadistic pseudo-identification with the father, namely the identification with the aggressor or the identification with the 'predator self-object'. This identification helps as a defense mechanism against feelings of longing, as well as murderous rage towards the emotionally (un)dead mother. In some accounts, the rage and hatred towards the (un)dead mother was more consciously expressed than in others.

Thematic analysis showed that there were not considerable differences in the quality of the patients' relationship with the maternal object between the sadistic and non-sadistic psychopaths. Sexually sadistic psychopaths, however, reported more severe traumatic experiences with their mothers. The (un)dead mother of the sexually sadistic psychopath appeared to be primarily abusive and neglecting, whereas in non-sexually sadistic psychopaths she was cold, distant and indifferent. The basic affect in sexually sadistic psychopaths towards their mother was intense rage and hatred, whereas non-sexually sadistic patients appeared to be angry and frustrated, but not enraged. Surprisingly, there were only two patients that described all positive and perhaps a rather idealised relationship with their mothers. One was a sadistic psychopath who scored considerably high on the ASP, and the other one was non-sadistic.

The (un)dead mother in sadistic psychopaths

Three patients reported that they were severely abused by their mother. A sexually sadistic psychopath described it as follows:

"I was very severely abused by my mother until I ended up in care by the age of 8. By the time I was there I'd been in the hospital 4 or 5 times. I broke my legs; I broke my arms. She was very violent towards me."

(MEIGF53)

The same patient got very upset and angry when I used the word 'mother'. He previously called her 'that thing' and asked me to call her 'B', making it very clear that he did not consider her as his mother. In his narrative, the concept of the (un)dead mother became evident as he portrayed a mother who was not only unavailable, but did not display any emotions, not even, as the patient said, anger or frustration. His rage was particularly evident when he was describing the deadness of his mother, who is now 'full of life' in her nineties. The patient said that he feels hatred towards her.

"She is not my mother. Don't call her like that. I call her B. She is not my mother; she is not my mum. She never will be… You know…*that thing – so called – my mother, she is in her early nineties now and she is full of life, believe it or not. I haven't spoken to her for 38 years. But anything that has to do with B. I just had to pretend for. She was supposed to be there to protect, love… but never did. 5 years… 4.5 years after I was born, she gave birth to her second child, it was a girl which she wanted… she lost all interest in me completely… even anger. She wasn't interested. Nothing. Never. She never made me feel loved and accepted."*

(CLBKO39)

Several sadistic psychopaths conveyed feelings of frustration and rage towards their mothers, whereas others struggled to articulate their thoughts and feelings about the quality of maternal care they received. The emotional absence and coldness of the mother, however, was reflected in almost all patients' narratives. The patient with the highest score on the ASP described his relationship with his mother as virtually absent:

"Well… this is the thing… this is the thing… The actual issue with my mum, was that she was never there. She tried to look after us. I think, but she was very cold and distant. She was emotionally absent. She was always gloomy and strict with us."

(CLDOO49)

Other patients reported that the presence of their cold and distant mother made them feel anxious and upset. They also stressed the lack of boundaries and the failure of their mother to protect them from hurting themselves by either using psychotropic drugs or participating in antisocial and criminal activities.

"I don't (think she took care of my needs). For example, my mum used to let me smoke hash you know…I don't think I was looked after the way I should have been. Because your parents to allow you to smoke drugs, is not too good you know... She made me feel upset, you know. But I don't think is all down to her. I think she was ill you know."

(CLEJA29)

"…It was quite difficult because we had a shop. My mum… from what I know, my granddad, his wife took care of me. Yeah… my mum had a job to do and my dad would take care of me. I don't think my mum showed much love because later on when I met my mum, even now, she

tries to show that love to my children and if you set back from that picture and look at it you are looking at a mother who is trying to show love to a child that she hasn't given to her own. I am trying to have a connection with my mum. I never asked my dad why, or if or what and I am never gonna ask my mother the same question. What happened in the past just stay in the past but not forget the past."

(MEIFR52)

The same patient continued and portrayed the actual picture of the 'dead mother': a mother who is not only failing to show love and affection, but who actually cannot protect her children from the abusive 'predator- father':

"If I was her only child, I would be happy. What she did (put me into care) was very hurtful for me… I think what I felt from my mum was abandoned and let down. And even she says that she tries hard she could have left any time she wanted, she proved it. And I think what hurt me the most was the fact why did you let us take that for a whole year of the abuse when you could have walked away any time you wanted."

"So, I never had that real connection with my mum, although I tried but I feel that my mum did not see me; she saw a can of beer. When she looked at me, she saw my father. Because I look like my dad… I met my mum when I was 17 at a care home. They said to me: 'Look they found your mum and there is the chance to go and live with her for the last year.' I thought, great news, fantastic. And she said no, she didn't want me. I couldn't believe it. She actually abandoned me the second time now. Only this time it hurt."

(MEIFR52)

All patients felt rejected and deeply wounded by their mother's absence. Some of them were more able to express their pain and sadness and others converted the mental pain to rage and hatred towards a mother who rejected them:

"Hm… I don't know if I can answer that one because when I was growing up my sister looked after me and my grandparents… not my mother really. I preferred to stay with my sister for example than with my mum… When I was born – and this is something I was told – I was born with a twin sister who died during birth. My mother did not want to look after me and my grandmother agreed to take me home."

(CLCCO38)

The (un)dead mother in non-sadistic psychopaths

Similar to the sadistic psychopaths, non-sadistic psychopaths' narratives reflect an absent, non-responsive and distant mother. Although there are not considerable differences in the quality of the maternal care, one apparent difference between the two groups is that non-sadistic psychopaths described their maternal object with less hatred and rage compared to the sadistic psychopaths:

"My mum is very religious, Roman Catholic. She always went to church every day. She claimed that nobody cares in the end. Very, very bad things happened. She was not allowed to show much love. When I was in the household, I was sleeping in my parent's bed, between my father and my mother… deliberately. So, nothing could happen. I made her cards and presents. I loved my mother and father a lot but a lot of bad things happened. Not very often... It was a cultural thing. And my father did not allow her to show any affection. But she saved me from killing myself."

(CLDEC49)

Several non-sadistic psychopathic patients reported traumatic experiences of abuse by their mother, struggling to find words to describe her character:

"My mother was alcohol depended. It was a difficult childhood… my mum used slaps and blackmail… and she was very… what's the word… hard and cold."

(CLERQ31)

When the same patient was asked to elaborate more on his relationship with his mother, he said:

"She did not show me too much affection. She went to work. She came home. She smoked too many cigarettes. And it was a very selfish way to raise kids up. She was not protective… I didn't get on with my mother. She never really gave any affection."

(CLERQ31)

When asked to what extent he believed his mother took care of his needs a severe psychopathic and sexually sadistic patient said:

"Very very small… Very rarely she showed affection and love and calmness. Looking back… for me… putting me in small place I used to become very angry and frustrated. Used to break things… shout and scream and fight with my brothers, you know."

(MEIGV6)

"She never made me feel loved and accepted… But I know that deep down my mum loves me. It was just the way she was brought up. My mum was like… she doesn't show feelings, emotions… you know… In my family we don't do a lot I love you, hugs and things like that."

(MEICR35)

Other patients did not want to reveal much information about the relationship they had with their mother and they were rather brief and laconic when asked to describe the extent to which they felt that their mother made them feel loved and accepted, as well as how often she expressed her affection towards them:

"No, she didn't care at all. Zero. Never."

(CLCBV53)

The 'as if' mother

The second sub-theme that falls under the major theme 'Early relationships with the primary caregivers' is the 'as if' mother. It refers to a fake and rather idealised picture of certain patients' mothers, who behaved 'as if' they were loving and caring. On several occasions, patients' narratives were found to be considerably different and sometimes totally different to what was written in their file with regard to the relationship they had with their mother.

As originally described by Helene Deutsch (1942), the 'as if' character refers to an emotionally impoverished individual who behaves 'as if' they were normal. Deutsch (1942) argued that the relationships of the 'as if' personalities are devoid of warmth and emotional intimacy and there appears to be a lack of affectivity in general. The 'as if' individual's relationship to the outside world appears to be impoverished and they experience feeling of emptiness and depersonalisation (Solomon, 2004).

The sub-theme 'as if' is not so much used to describe the actual quality of the maternal care or the mother's behaviour towards the patient, but it mostly reflects the patient's need to restore a picture of a loving and affectionate mother who compensates for all the feelings of frustration and anger. The remake of the mother in the patient's fantasy aims to help to alleviate painful and devastating feelings of rejection, and also to protect the internalised picture of the mother by keeping it 'all good' and safe from feelings of rage and hatred towards her.

The 'as if' mother in sadistic psychopaths

Several patients described 'all good', positive relationships with their mother; however, on some occasions that initial perfect image of the mother started to change later in the interview as there were a lot of contradictory and sweeping statements. One patient described the need for idealisation of his mother in a very lively way by using the metaphor of the 'flat land':

"You remember the flat land, don't you? It doesn't exist but you can put yourself there. If you are in flatland nothing upsets you. You know it is not real, but it makes you feel better for that moment. Because when you come back to reality, you can't do that in the real world."

(MEIFR52)

When he was asked to describe his relationship with his mother, he initially said that his mother was 'a good woman'. This positive statement changed very quickly when he was invited to share his experience of the extent to which he felt his mother made him feel loved and accepted. He conveyed to me that his mother did not show much love and affection to him as he looked like his father.

When the patient continued talking about his mother, he ended up describing the actual picture of the 'dead mother': a mother who not only fails to show love and affection, but who actually cannot protect her children from the abusive 'predator' father:

"If I was her only child, I would be happy. What she did (put me into care) was very hurtful for me… I think what I felt from my mum was abandoned and let down. And even she says that she tries hard she could have left any time she wanted, she proved it. And I think what hurt me the most was the fact why did you let us take that for a whole year of the abuse when you could have walked away any time you wanted."

(MEIFR52)

Another patient described his mother as 'sort of ok'. He conveyed to me that his mother 'was a bit caring' and 'being around'.

"Hm... Parents, parents… I will only discuss one… My biological father did not bother as such and my mother was sort of ok… She was a bit caring. She was around. But she divorced, married again, then divorced again… But it was okish…"

(CLCCO38)

This statement, however, changed considerably a couple of minutes later when he stated that his mother did not want to look after him:

"When I was growing up my sister looked after me and my grandparents… not my parents really. Both my sister and my grandparents looked after me well. I preferred to stay with my

sister for example than my mum… My mother did not want to look after me and my grandmother agreed to take me home…"

(CLCCO38)

That same contradiction was present in several other patients as well:

"My relationship with my mother was ok… I think she tried… She was alright…"

(CLDOO49)

And few minutes later he said:

"The issue with my mum was that she was never there. She looked after us well, I think, but she was very cold and distant… She was emotionally absent… She was always gloomy and strict with us."

(CLDOO49)

There were also more emotionally neutral statements as, in my view, several patients were very reluctant to revisit painful experiences. Other patients denied the traumatic experiences they had with their mothers, and attempted to present *a very different picture* of their mother:

"When I was 4-5 my mother and father split up. I didn't see my mother until I was about 12. She didn't live far away from us, you know. I started living with her when I was 13-14 years old. And she always made sure that there was food on the table. She seemed alright, my mum… She was more friendly and more talkative and got more advice from her, more care

from her… The door was always open for me, you know what I mean. I think she liked me. We were not a huggie and kissy kissy family, you know what I mean. She expressed her affection towards me all the time. All the time".

(CLCCO38)

This patient presented a very idealised picture of a mother who abandoned him at the age of 4 and who he hadn't seen for 12 years. However, there was no reference to any hurtful feelings of abandonment or anger, or sadness in response to separation. That made me feel that the patient had to protect his (internal) idealised picture of the mother that he loves by separating it from the mother who he hates. Therefore, he had to keep apart the mother who abandoned him and who he hates, from the mother that he loves.

The 'as if' mother in non-sadistic psychopaths

There was no variation in the sub-theme of the 'as if' mother between sadistic and non-sadistic psychopaths. Several non-sadistic psychopaths denied the loss of their maternal care and attempted to present a picture of their mother 'as if' she was caring and affectionate. When questions about their relationship with their mother were asked, patients either provided very short answers, or tried to avoid the question by changing the subject or talking about something totally different:

"My mum was very caring and supportive. She pushed me because she knew I could do better than I was… But she used to tell us off… you know 'I will tell you off if you do something wrong.' That kind of thing."

(CLLSH36)

A patient who was adopted when he was 9 days old, met his biological mother when he was 19. He had the option to stay with her, but he chose not to, as he felt that his biological parents were 'too good for him':

"They (his stepparents) turned around and said to me that if I wanted to get in touch with them (his biological parents) they could help me. But I didn't. I did meet them eventually and thought. Hold on, these people are too good for me and I walked out. And I heard my biological mother saying to one of my sisters:'We tried but he did not want to speak to us'. And I said: 'No, no that's not the case, you are just too good to me'."

(CLDWG54)

When he was asked to describe his stepmother, he paused for a long time and was very reluctant to speak about her. He declined to say more about it by saying that this is all he could say to me.

"I only know her as a mother… My (step)mother was… (pause for about 20 seconds)… she was ok. That's all."

(CLDWG54)

The predator paternal object

The predator paternal object in sadistic psychopaths

The sub-theme 'predator parental object' is a metaphor that refers to the picture of a sadistic father who is mostly physically abusive towards his children. The father-predator displays savage aggression towards his children, who become utterly helpless and ultimately the prey of his physical, as well as, emotional abuse. Like a carnivorous predator, the father-predator is ready to attack but the child-prey does not know when he will be attacked. The use

of the word 'predator' was based on a repetitive dream that was described to me by a psychopathic forensic mental health patient who was severely abused by his father and who, in the dream, was constantly chased by sharks, lions and tigers. Every time the patient saw the dream, he woke up in the middle of the night in a state of panic screaming for help.

Although not to the same extent, the sub-theme of father-predator was present in several patients' accounts.

"My father was an alcoholic and he attacked my mum and beat us all. He was a very violent man. I was 5 when he left me. He was a nasty, aggressive man. Most of the time he was, as I said an alcoholic. He was drunk all the time."

(CLBOW38)

Another patient shared a very similar experience. He described in great detail the extent to which and how specifically his father was abusive towards him.

"My father was an alcoholic. He was abusive when he was drunk to the whole family including my mum. At the age of 4 going to the age of 5 I was the only one my family found reasons behind me… and I worked out that being in different parts of that flat would have been different beatings. For instance, if I was in the bed I was trapped, there was no way out for me. So, beating were more powerful because he could get me more. If I was on the front, the beating were hurting because of the size of the room. He had the ability to use the whole force of his hand."

(MEIFR52)

The predatory nature of the father's aggression and the atavistic fear the patient experienced as a child was present in several narratives:

"Rather than waiting for mum to come in, I worked out to stand by the door and unfortunately, I didn't find myself to be that clever because I used to climb out the window at night, or when locked out of the door then come back through the window. So, he was waiting in the door for me and I waited there and got abusive language like 'you bastard'. You know?'

(CLBKO39)

"My father contradicted himself a bit. On the one hand he would be a violent man and on the other hand he would wake me up when he went to work. And he would take me out with him shopping or to his work showing me off 'this is my son'. How can you be so horrible and at the same time how can you be so nice?"

(CLESA29)

Hatred towards the father-predator was the basic affective state in most of the patients who were abused by their fathers. The hatred and rage manifested in violent phantasies and murderous wishes:

"I felt hatred towards my father when I was growing up. Real hatred. I felt I wanted to hit him when I saw him… So, I was thinking… 'Is that bastard still alive?'"

(CLDOO49)

The predator paternal object in non-sadistic psychopaths

The father of the non-sadistic psychopath was also described as an aggressive, violent and sadistic. Similar to the sadistic psychopaths' narratives, non-sadistic psychopaths also described very traumatic experiences with their fathers, including emotional, sexual and physical abuse.

"I was sexually assaulted by my father as a child… My father threatened to cut my mother's throat. Threatened to rape her… He talked about homosexuality with me when I was a child… He said this to other people… I was actually growing up gay. I was exposed to pornography when I was a child… Male pornography with men. No women but men."

(CLDEC49)

Most patients described more than one type of abuse by their father:

"Very intense. He used to call me a bastard. He was very aggressive towards me. He used to beat me. He was beating me with the belt… this was mental."

(CLERQ31)

Some patients reported that their father was aggressive towards them when he was drunk:

"*He was an alien to me really… He was aggressive towards me when he was drunk. During weekends. Every other time he was at work and we stayed out of his way."*

(CLCBV53)

Some patients felt that psychological and emotional abuse by their father traumatised them more than physical abuse:

"He was always angry. He used to tell me off… My dad used to shout a lot. And that used to frighten me. I would rather he hurt me than shout. Because he used to come home and shout at me calling me an asshole and this kind of things. I would rather him beating me physically because he actually did psychological damage to me."

(CLLSH36)

The predatory nature of the psychopath's father's aggression was very vividly described by the same patient. This type of aggression involves violent outbursts and the victim of the aggression does not know, as the patient said, what is going to happen from 'one day to the next':

"This made me frightened of him you know… because I never knew from one day to the next how he was going to react. On one occasion he accused me of stealing his wallet, but I didn't take his wallet. And when I came back home, he punched me in the head… I will never forget it. It was so frightening."

(CLLSH36)

Theme 2: Traumatic experiences in childhood

The theme of Traumatic Experiences in Childhood was certainly the biggest overarching theme that emerged from the data. Discussions revealed that both sadistic and non-sadistic psychopaths experienced one or a few and some of them experienced all of the following

early aversive childhood experiences: neglect; parental humiliation; psychological abuse; helplessness; and foster home placements. Some participants experienced these traumatic experiences to a greater and some others to a lesser extent. There were no considerable differences between the narratives of sadistic and non-sadistic psychopaths in this respect.

Neglect

Neglect in sadistic psychopaths

Since 6 out of 8 sadistic psychopaths experienced parental neglect there are many examples to choose from to demonstrate its importance. Some patients experienced neglect by their mother, whereas others were neglected by their fathers. On several occasions, however, patients experienced neglect by both parents.

"Hm… parents, parents… I will discuss one… My biological father did not bother as such and my mother was sort of ok… My biological dad did not contact me probably… Hm… I don't know if I can answer that one because when I was growing up my sister looked after me and my grandparents… not my parents really. My mother did not want to look after me and my grandmother agreed to take me home."

(CLCCO38)

Although paternal neglect was painful for the patients, some of them also experienced relief, alongside pain, when their father left them as they felt that they were protected from his abuse:

"I was 5 when my biological father left me. He was a very violent man. Nasty and aggressive."

(CLBOW38)

Other patients felt that parental neglect made them feel helpless as there were no boundaries to protect and make them feel safe. They felt that they were aliens to their own families. As such, they lost any sense of belonging:

"I was treated like a foster child. I had no boundaries. No rules. The more I was outside of the house the better it was for her. My father used to work 12 hours because he was a builder. So, I never really saw him."

(MEIGF53)

Some patients felt that they were mostly emotionally neglected. They described that there was financial support and 'food on the table' but no emotional contact and intimacy. The 'emotional food' was virtually absent:

"I didn't see my mother until I was about 12. My father was very hardworking man, very strict man. I never loved him. Kept himself very quiet. But I respect him because he always kept the roof above us. He always made sure there was food on the table. He always paid up bills, he was never indebted or anything… I am looking backwards, you know… he never showed any love… I can only remember taking me, taking the family to seaside, holidays. But I didn't really speak to him… He was a very quiet person... There wasn't love, touching, hugging or playing with us."

(CLBKO39)

"Mentally I had to build certain factors I could rely on myself. I think my parents tried to take care of my needs. Food was always on the table… My father was such a strong character. I can't remember much of our relationship to be honest… The issue with my mum, was that she was never there. She looked after us well, I think, but she was very cold and distant."

(CLDOO49)

Neglect in non-sadistic psychopaths

The level and intensity of parental neglect could not be differentiated within the group of the non-sadistic psychopaths. It appeared that patients felt that emotional neglect was much more traumatic than the actual neglect. They drew on the dialectic between having a parent who 'pays the bills' or 'puts a roof over their head' and at the same time a parent who 'did not bother as such' and hadn't really looked after them. Like the sadistic psychopaths, non-sadistic psychopaths experienced mental pain due to the emotional absence of their primary caregivers.

"There were a lot of arguments at home. My stepdad was on drugs. There were a lot of drugs in the house and things like that. Arguing, screaming, fighting… I wasn't looked after properly."

(MEICR35)

Other patients appeared upset and angry and more able to talk openly about the neglect they experienced from their parents. They emphasised the lack of love, affection, as well as protection:

"*(My relationship with my parents was) Bad. My parents were quite neglecting, domestic abuse, violence drugs. No love, no care. They didn't care at all… Zero… Never."*

(CLCBV53)

"They did not show me too much affection. But everything looks happy when I go back, but I actually wasn't… They went to work. They came home. They smoked too many cigarettes. And it was a very selfish way to raise kids up. They were not protective."

(CLERQ31)

"We lived in poverty and had a very difficult upbringing really. We were always arguing and fighting and hungry and… very poorly looked after. I had a very difficult childhood really… So, I look back at my parents and I believe that I could have a better childhood, but I don't hold any grudges. Because I had a difficult upbringing… I don't know if that answers your questions."

(MEIGV64)

When the same patient was asked to elaborate on the extent to which he thought his parents took care of his needs when he was a child, he said:

"On a scale of 1-10? Probably 2 or 3 maybe… As I say there wasn't a lot of money around. Both my parents were alcohol dependent."

(MEIGV64)

Parental Humiliation

10 out of the 18 psychopaths suffered humiliation from one or both parents. Parental acts of humiliation mostly occurred during the patients' childhoods. There were certain kinds of humiliation that were difficult for the patients to tolerate. Some of them were related to sexuality (e.g. inappropriate sexual comments); lack of masculinity and manliness; or abusive

language. Humiliation usually co-occurred with other aversive experiences such as neglect or abuse. Given that psychopathic patients are very reluctant to reveal feelings of vulnerability, shame and humiliation, the identification of the sub-theme was based on implicit statements that reflect shame and humiliation. Given the defensive nature of the psychopathic personality, it is not surprising, however, that almost no psychopathic patient explicitly conveyed feeling of humiliation.

Parental humiliation in sadistic psychopaths

When humiliation came from the mother, it appeared more painful and traumatic than when it came from the father. Although, most of the patients expressed that they were more severely abused by their father than their mother, they were able to justify his actions and/or show some (pseudo) forgiveness to him. When feelings of humiliation were triggered by the mother's neglect or abusive behaviour, the patients were full of rage and hatred:

"She was supposed to be there to protect, love but never did… 4-5 years after I was born, she gave birth to her second child… it was a girl which she wanted… she lost all the interest in me completely… even anger… she wasn't interested… I got not emotional support from that woman in my whole life… All frustrations, the anger… were pushed away."

(MEIGF53)

"My parents used to tell me off all the time. That I was not good enough, I was not clever enough, I wasn't this and that… You know?"

(CLBKO39)

Most of the patients used psychotropic drugs and alcohol as a 'retreat' from the mental pain they suffered; they claimed that drugs and alcohol helped them to contain the intolerable feelings of fear and humiliation:

"I chose drugs and alcohol trying to suppress my emotions. But they never went away. And I remember that my old man, I remember one time, he didn't have to come in the house to make me wet myself."

(MEIFR52)

Parental humiliation in non-sadistic psychopaths

Parental humiliation appeared to be frequent in psychopaths who exhibit less sadistic traits. The difference between the two groups, however, was that non-sadistic psychopaths were more able to express and talk about humiliating experiences without denying them or trying to avoid the discussion.

"Before my index offence I was really vulnerable. I had personality disorder issues and I realised that when I was doing things that made me upset – that made me feel vulnerable. So, I had repeating behaviours, like gambling etc… I was going through a really hard period of time in my life… no money, no girlfriend… no job. So, the quality of my life at that moment was very frustrating… I was more angry with myself than with anyone else."

(MEIIV31)

"He used to come and shout at me calling me asshole… That made me feel very low… That was really painful."

(CLLSH36)

Other patients were not able to cope with feelings of humiliation and they used self-harming or promiscuous sexual behaviour as an antidote to the humiliation they experienced from their parents:

"I was sexually assaulted as a child… I had poor self-image (because of this). I was also self-harming. I have false memory syndrome. It's blocking everything out… There is one phrase that sticks in my heart: 'Suck my cock.' My mother said that my father wanted me to do that.

Parental Cruelty

The sub-theme of parental cruelty primarily refers to three different destructive types of abuse, namely physical, sexual and emotional. Parental cruelty was certainly the biggest sub-theme and the one that had considerable impact upon adult personality development in both sadistic and non-sadistic psychopathic patients. Since most of the participants experienced more than one type of abuse from their primary caregivers, the sub-theme 'parental cruelty' was chosen as most appropriate to describe the three aforementioned types of abuse. Generally, 15 out of 18 psychopathic patients, either sadistic or non-sadistic, experienced one or more types of abuse. There were only three patients who reported no traumatic experiences at all.

Parental cruelty in sadistic psychopaths

Physical abuse, which was most commonly co-occurring with emotional or psychological abuse was very evident in sadistic-psychopaths' narratives. Most of the patients were severely abused by their parents. On most occasions, the abuser was the father, who was earlier described as a father-predator. As discussed above, the sadistic psychopath's father was both physically and psychologically abusive.

"... In different parts of the flat would had been different beatings. For instance, if I was in the bed I was trapped, there was no way out for me. So, beatings were more powerful because he could get me more... He (father) got abusive language like 'you bastard'... And I remember that my old man, I remember one time, he didn't have to come in the house to make me wet myself."

(MEIFR52)

"He used to call me a bastard. He was very aggressive towards me. He used to beat me. He was beating me with the belt... and this was mental."

(CLDEC49)

On a few occasions, the victim of abuse was not only the patient but also the patient's mother. Witnessing the abuse of their mother was very traumatic for the patients:

"My biological father was an alcoholic and he attacked my mum and beat her. He was very violent man... It affected me as well."

(CLBOW38)

Several patients, however, spoke about being severely abused by their mother as well.

"I was severely abused by my mother until I ended up in care by the age of 8."

(MEIGF53)

Although sexual abuse was not frequent among the sadistic psychopaths, one patient described very vividly how he was seduced and subsequently sexually abused by his father:

"I was sexually assaulted as a child, but I had no memory, no memory at all… I was exposed to pornography when I was a child… There is one phrase that sticks in my head 'Suck my cock'. My mother said that my father wanted to do that. I wrote it down at my notebook when I was at school and someone read the notes and asked me what I meant."

(CLDEC49)

Parental cruelty in non-sadistic psychopaths

Like sadistic psychopaths, non-sadistic psychopaths experienced abuse from either one or both parents. Physical and emotional abuse was present in most of the patients; however, no patient reported sexual abuse.

"There were always arguing and fighting… It was a difficult childhood… my mum used slaps and blackmail… and she was very… what's the word… hard and cold… She was always quick to slap you round the head."

(MEIGV64)

"Bad my parents were quite neglecting, domestic abuse, violence, drugs… (He used to beat me) when he was drunk."

(CLCBV53)

"On one occasion he accused me of stealing his wallet, but I didn't take his wallet. And when I came back home, he punched me in the head… and I run in the backyard and the dog attacked me… I will never forget it. It was so frightening."

(CLLSH36)

Foster Home Placements and Adoption

Foster home placements and adoption in sadistic psychopaths

Although being adopted or growing up in foster homes does not necessarily constitute a traumatic experience as many people grow up with loving and caring stepparents, it became evident that many of both the sadistic and non-sadistic patients were either adopted or grew up in foster home placements. It is not clear what impact adoption had on these patients; however, it may have been resented by them as they may have experienced adoption or being put into care as rejection or abandonment. Furthermore, it is very likely that these patients experienced neglect and/or abuse and their attachments were disrupted at a very young age. In England and Wales, a child will be adopted or fostered because they have been legally removed from their parents primarily due to parental abuse and/or neglect. Therefore, adoption and foster home placements may indicate that a child experienced some form of parental cruelty and as a result they were not able to form secure attachments to significant others.

Overall, 5 out of 8 sadistic psychopaths were either adopted or grew up in care or foster homes:

"I ended up in care by the age of 8."

(MEIGF53)

The feeling of rejection and abandonment was more evident in the following narrative:

"I was put into care at the age of 5.5-6 years and there was a complication because there was many of us. But before that happened my mum decided that she had enough, run off and she took my little brother with her. The rest of us were put into a home. I never understood why she took the baby only. Why she did not take us all? Anyway…"

(MEIFR52)

The same feeling of rejection and abandonment was described by another patient who was raised by his grandmother because his biological mother did not want to look after him:

"My mother did not want to look after me and my grandmother agreed to take me home."

(CLCCO38)

Foster home placements and adoption in non-sadistic psychopaths

Surprisingly, only 2 out of 10 non-sadistic psychopaths grew up in care:

"I went into care when I was about 9-10 years old."

(MEICR35)

"My parents were workers, got together and started family… but I found in later years that I was adopted."

(MEIGV63)

Helplessness

As described earlier, most sadistic and non-sadistic psychopathic patients experienced severe early relational trauma including neglect and various types of abuse from either their (un)dead mother or their predator-father and on several occasions, from both of them. During the interviews, the participants were asked whether they could rely on anybody to make them feel better and/or safe during those hard times. When I was reading the interview transcriptions, I thought of Dante's Divine Comedy (1310), and particularly the first part of it which is called Inferno (Hell). I felt that Dante's vision of hell was very much reflected in the patient narratives; they appeared to feel utterly helpless about their 'parents from hell', being trapped in a family environment which was hell on earth.

Helplessness in sadistic psychopaths

Overall, 5 out of 8 sadistic psychopaths spoke about feeling utterly helpless, alone and isolated. They conveyed that there was no one around to help and support them. Nobody was available to rely on, so the felt they had to 'manage alone' as they did not trust anybody:

"No… I didn't rely on anybody. There was no one around… People were really bad to me."

(CLDEC49)

"I would say no, because I couldn't really talk to anyone… I managed alone. I didn't have anyone to talk to, so I didn't have a choice. I couldn't trust anybody."

(CLCCO38)

Other patients received some help; however, they felt that it was not enough to make them feel safe and secure:

"Well… Obviously with my parents I had to run off to neighbours' houses depending on them… They were scared of what my father would do if he ever found out… They made me feel better to shut me up. 'Don't tell your father you are here.'"

(MEIFR52)

"(I could rely on) My grandparents… They helped as much as they could. I got more emotional support from my grandparents than I ever got from 'them' (parents). Was it enough? No… This is not what the people expected as the conventional way of support, we can't all be the same way or anything like that. I got no emotional support from that woman (mother) in my whole life. All the frustrations, the anger, were pushed away."

(MEIGF53)

Helplessness in non-sadistic psychopaths

The sub-theme of helplessness was also present in non-sadistic psychopaths, however, not to the same extent. Nevertheless, non-sadistic psychopaths had also experienced isolation and hopelessness as there was no one around to support them to escape from their traumatic parental environments:

"Not really. I used to sort out my problems myself the best way I could or tell them some other."

(CLDWG54)

"No… (I coped) On my own. A lot of things happened in my life. No support at all. I was on my own."

(CLCBV53)

"No, not really. I just got on with them to be honest… Just coped."

(CLERQ31)

Other patients tried to reach out for help, but their significant others rejected them:

"No one… When I had troubles… well, when my mum was around, I was like: 'Mum, I am a bit concerned blah blah blah…' child language you now… But she was like 'Don't bother me, I got other things to worry.'"

(MEIGV64)

Theme 3: Aggression and Sadism

The Acting out of the Beaten Child

Given that all the participants were forensic mental health patients, aggression and violence were prominent in their narratives. Although all patients were convicted for violent or sexually violent crimes, not everybody was comfortable enough to speak about their own aggression and sadistic behaviour. The aim of the second part of the interview, namely 'Aggression and Sadism', was to identify the differences in the function of aggression between the sadistic and non-sadistic psychopaths, as well as to explore the dynamics of aggression in the construct of psychopathy.

Although there were some differences in the function of aggression between sadistic and non-sadistic psychopathic patients, their violence and aggression appeared to be mostly affective/reactive. This is not in accordance with the clinical literature that suggests that psychopathic patients tend to display more instrumental aggression. This finding, however, may be related to the fact that the vast majority of psychopathic patients in the current sample scored lower than 30 on the PCL-R (only 2 patients scored above 30). That may indicate that the more severe the psychopathy is, the more instrumental the psychopathic aggression will be as well. Furthermore, it may also be an example of defensive use of language, where the patients wanted to present themselves as responding to a threat, rather than being violent proactively. A plausible hypothesis for this might be the tendency that psychopathic patients have to con and manipulate the clinician/researcher, which is idiosyncratic to their personality structure.

The sub-theme was named 'The Acting out of the Beaten Child' as it became apparent that the function of aggression in both groups was mostly a way to protect their vulnerable selves and to defend against the pain and humiliation they suffered in their childhoods. In those cases, aggression was a 'retreat' to a safe place; a place where internal and emotional homeostasis was temporarily achieved.

The acting out of the beaten child in sadistic psychopaths

Aggression in psychopaths who displayed more sadistic traits had, as expected, more sadistic elements. The sadistic nature of their aggression, however, was not simply related to the feeling of pleasure that derives from the hurt and humiliation of another human being but it was mostly an effort to control the impact that the words and acts of other people had on them. To express it differently, sadistic aggression in this group appeared to be a way to protect the psychopath's psychological self and to keep their internalised wounded child safe and sound. On other occasions, sadistic aggression was, as the name of the sub-theme

denotes, the revenge of the beaten child; a child who will not tolerate abusive behaviour anymore. That involved a disidentification with the internal wounded child and a concordant identification with the aggressor. Another characteristic of the sadistic violence in this group was that it was not primarily directed at strangers (e.g. at people that they did not have any contact with, or people whom they had simply had an argument with), but at people who had a more intimate relationship with them (e.g. staff members, carers, fellow inmates etc).

"To be honest with you I am not really aggressive person… You know… I would never attack anybody unless they attack me. I am not talking about an old lady or an old man… Someone that is a good fighter… 'come on let's have it' … In that occasion, I would fight the best I could… but if you are talking about an old man coming and beat me then I would just walk away."

(CLBKO39)

The same patient continued and let me know that he wouldn't tolerate any abuse or bullying and made it quite clear that he was not 'weak' but he could 'handle' himself:

"I try to avoid violence at all cost; if I can walk away, I will walk away but I am not saying that I can't handle myself. I can handle myself. I got involved in fights in prison, but this is the last resort, the very last resort. But I wouldn't tolerate someone bullying me… That's a bully. It's different."

(CLBKO39)

"I always used to punch those that create negativity about your situation. Those who look down on you. Do you know what I mean by negativity? I mean pushing people away, turning them down…"

(CLDOO49)

Other patients also stated that they tend to avoid violent behaviour, but they won't also accept being bullied by anybody else. There was an unconscious identification with their weak and vulnerable self, reminding them of the period they were being abused by their primary caregivers, as several patients said that they wouldn't be aggressive to someone who is weaker than them. When, however, patients became more in touch with their fragile and vulnerable self, they appeared to defend against feelings of helplessness and vulnerability by demonstrating their power and superiority, making it quite clear that they were not that 'beaten child' anymore; that they were not afraid:

"I am trying to avoid trouble. I haven't really been violent for years. But as I said, if someone hits me like, you know, I would beat them up. I don't pick on the weak people. I pick on people they can handle themselves. They underestimate me… I never lost a fight. I am quick and everything. I remember I was in prison and there was two men, everyone was scared of them, both of them were carrying knives and I go into a fight with one of them and I stabbed him… All the gangsters were in the room and the villains and they thought 'who is this guy?'"

(CLESA29)

The same patient continued by letting me know that he used violence to show people that they 'can't mess with him':

"You know I don't want blood in my hands, nobody wants but I didn't have a choice. Since that day I don't really keep weapons on me. I do make threats and stuff, but this is my safety guard, you know what I mean. It's a bit of a show… to show to other people 'just don't mess with me'. But in the end of the day I am not a violent person, never had been."

(CLESA29)

The need to be bigger and stronger than anybody else is illustrated very vividly in the following passage of a sexually sadistic patient:

"I can only say the way I feel it and I don't expect you to understand that. It's easier in an environment surrounded by violence 24/7 and all you have around you are violent offenders, and a lot of them are violent prison officers… the only way to survive in the jungle is to be the kind of the jungle."

(MEIGF53)

Some patients were aware of their aggression and the fact that they were prone to violent behaviour and tried to protect themselves, as well as others from their violent outbursts and sadistic behaviour:

"I try to contain as much (aggression) as I can. But personally, I am aware that I get angry quite easily but I try to contain as much as I can… They way I think that I retreat to my room because if I am behind the door, I can't hurt anybody, either physically or mentally… because I got a really acid tone. And I can do more damage with my voice rather than I can do physically."

(MEIGF53)

The same patient described how he became physically violent for the first time in six years. What is apparent in his narrative was that his violence was a way of escaping intolerable feelings of frustration and vulnerability. It was an acting out as the patient was not able to contain those feelings:

"I was recognised as one of the most violent individuals within the prison system. Someone could happen to walk on me and I would be on top of him in a second… I am not proud of that… Did you see the crack on the door? I did that… And this is the first time in 6 years that I physically got violent… And that was because someone said something really stupid to me. And the reason for that… it was like an instant flashback. Because that person said to me: 'Come on then, punch me in the face. I don't care. Punch me everywhere you want.' And that pushed me right to the edge. I aimed at the wall because I didn't want to hurt anybody. But when I punched the wall it cracked but the effect that it had stopped the argument. He was scared. The person who said 'Do that' became so frightened. I needed that aggression out of me. But the minute I did it I walked to my room."

(MEIGF53)

Other patients spoke about the rage that they had inside as a result of the abuse the suffered from their parents:

"Still got rage inside me. I am not really physical now; I am only verbal. I swear, shout, threats but I was only violent when I was drinking alcohol and doing drugs. I become aggressive when I have arguments with staff…. (Violent behaviour) Relieves the anger… But I don't feel nice myself when I am angry. It relieves the tension but it's not nice to be angry."

(CLBOW38)

Other patients used sadistic violence when they felt let down, hurt or when they wanted to keep someone away. A patient described his need to be violent using the metaphor of the 'internal saboteur' who takes control of his behaviour:

"I think I get mostly aggression when I feel let down for no reason… We become within ourselves that we feel hurt again… hurt is coming. I have the saboteur in me… I don't let the person get too close to me, I am starting to feel uncomfortable. Because I don't know what the person wants. And normally in the past this did not have a happy ending for me. If the saboteur doesn't work, then I become sarcastic. Like, in other words, hostile. If that don't work, the third one I become an abusive sarcastic… When I am in that state of mind, I don't feel anything for that person. I just want him to go away… And the fourth one I become angry. In other words, listen 'fucking go away'… and obviously the fifth one I become violent."

(MEIFR52)

The acting out of the beaten child in non-sadistic psychopaths

The subtheme of the 'acting out of the beaten child' was also present within the group of non-sadistic psychopaths. As aforementioned, however, there were considerable differences in the intensity and function of aggression, which was less frequent, less sadistic and less intense. Although violence in non-sadistic psychopaths was reactive as well, aiming to protect the psychological self, it was characterised by less rage and hatred compared to the sadistic aggression displayed by the psychopaths who presented more sadistic traits.

"I avoid violence at all cost. I had some verbal arguments with patients and staff but nothing serious to concern. When I am verbally aggressive, I do it because I want to stand up for people."

(CLDWG54)

"I don't (experience the need to be aggressive very often)… It's only every now and then. When I have blue mood. I don't really get aggressive. I have been here 5months, and in 5 months I had probably be aggressive about 10 times. I didn't hurt no one... you know…"

(MEICR35)

Other patients said that they used to be much more aggressive when they were younger; however, they feel that they can contain their aggression more efficiently now:
"(I feel the need to be violent) Sometimes … It used to be quite a lot when I was younger. Nowadays I am a bit older, so I am not so aggressive. I tend to be more straight-forward; I don't think of aggression, I just do it. Sometimes, like it happened last week… it just happened like that (sound). But I am not that bad… I am controlling it. But there is violence everywhere."

(CLCBV53)

Another interesting finding was that non-sadistic psychopaths were more reluctant to reveal and discuss their aggressive thoughts and feelings. When they did, however, they conveyed that they became aggressive only when someone is abusive to them:

"That is a tricky question inasmuch as… my answer to it will be I don't feel an urge to be violent or angry or aggressive. I am only violent defensively and aggressive defensively so if somebody tries to intimidate me I will verbally defend myself. And in doing so, my inner feelings become heightened and I become frightened and so I get aggressive with threats of violence. And when I have been attacked, I tried to defend myself. But I don't go around causing people problems. I am not a bully; I don't use violence as a means of influencing… but there are people who do that. When I step on my toes, I let them know that I don't like them stepping on my toes. I am not really a good fighter but I would defend myself and that's why I am verbally aggressive in first instance."

(MEIGV64)

"I had a couple… not a couple… I think 3 or 4 incidents last week when I was irritated by people. I pushed a patient over. The other one I threw some bread to a member of staff."

(CLLSH36)

Other patients said that they became aggressive when they felt uncontained:

"I was detained for assault on my carers. And not only my carers but on other patients. If I don't take my medication, I feel aggressive all the time. I am really distressed of what happened in my life."

(CLDEC49)

"Not often… Since my index offence, which was a serious offence with very high level of aggression, sadly killing someone at train station – I had maximum 2-3 incidents of

aggression, the last one more that 10 years ago… Before my index offence I was really vulnerable. I had personality disorder issues and I realised that when I was doing things that made me upset – that made me feel vulnerable."

(MEIIV31)

When the non-sadistic psychopaths asked on what occasions they experienced the need to be aggressive/violent, they mainly said that they did it when they didn't feel respected.

"When I am not respected... you know… When they take the piss out of me…"

(MEICR35)

Several patients claimed that they felt bad and guilty after an aggressive outburst:

"I feel horrible afterwards. I apologise to the person. The person apologises to me and we are alright afterwards."

(CLDWG54)

"I feel angry. I feel frustrated. I feel drained. Afterwards I tend to feel guilty…"

(CLCBV53)

Other patients said that violent behaviour and aggressive acting out helped them feel calmer and achieve a level of internal homeostasis:

"I become tearful. I become stressed. But after that I calm down. I just feel totally calm after."

(CLLSH36)

Theme 4: Predatory Fantasies

Predatory fantasies in sadistic psychopaths

The analysis revealed that many sadistic psychopaths experienced violent phantasies prior to the aggressive or sadistic act. The most important characteristic of those fantasies was that they were ego-syntonic. That means that the aggressive content of those fantasies did not create anxiety in the individual. Non-psychopathic, as well as non-sadistic participants experienced intense anxiety when they had violent thoughts and feelings. This, however, was not the case within the group of sadistic psychopaths, who were very comfortable talking about the predatory nature of their aggression when asked how they feel when they become violent:

"Just punching and kicking. Or grab them by the neck… That's it."

(CLCCO38)

"To be honest, you know what I mean, I am just a punch man. I just punch them few times in the face. I know where to punch people."

(CLBJO39)

Interestingly, the same patient talked about an argument he had with a big, masculine inmate and described his violent phantasies about him:

"What I wanna say to him, you are a big fellow, you sit down there is nothing stopping me coming right behind you with a pen or something and believe me I can take both of your eyes out mate."

(CLBJO39)

"Hitting them, which I have done… but… Thoughts… like beating them up."

(CLBOW38)

"Revenge."

(MEIGF53)

Other patients spoke about the object of their fantasies and most specifically the relationship they had with them. They conveyed that the more intimate the relationship is/was the more intense the aggression would be:

"Obviously, I have to pin point who the person is. Frist, if he is someone you know that makes it dangerous. Especially if you have a past relationship… So, you don't have to be sarcastic or abusive. You go straight to anger and violence."

(MEIFR52)

One patient said that the escalation of an argument can be so quick that he does not have time to experience any fantasies:

"I don't imagine anything in particular. It's just an argument mate that can escalate into a fight."

(CLDOO49)

Surprisingly, there was only one patient who openly admitted that he was experiencing sexual fantasies which he was not able to contain and thus he acted out on them:

"*All the time, I mean, I used to cope with different ways to deal with things of anger or aggression… So instead of externalising my thoughts I internalised them which made me feel better. They are internalised phantasies. I don't act out. I mean they are basically sexual phantasies and what I found out when for example at a young age I didn't really understand my personality… I was coping with feeling negativity, distress or anxiety… I would basically use sexual phantasies to relieve that tension… To make myself feel better. But when they were not really working, became more external. I mean these phantasies involved anything from pushing people… to touching people… To actually assaulting people, I suppose."*

(CLAVG47)

When asked about the frequency of these phantasies, almost all participants said that they did not experience violent fantasies very often and consistently:

"Not very often… sometimes they could be once or twice per day… and then at a time once or twice a month… they are quite frequent but not consistently every day."

(CLAVG47)

"I don't get them very often. I don't have bad thoughts but I must admit that I can have them... but it's very rare."

(CLBKO39)

Other patients said that they only experienced violent thoughts when they felt they were not respected:

"I only have thoughts when people don't respect me."

(CLCCO38)

Only one patient openly admitted that he had violent thoughts that disturb him:

"I do get them (often)… I have done now 6.5 years of (therapeutic) work. And even after 6.5 years I still go to sleep and I have thoughts I don't want."

(MEIFR52)

Predatory fantasies in non-sadistic psychopaths

Non-sadistic patients experienced considerably less violent phantasies. Furthermore, they were much more reluctant to reveal the content of their fantasies. Indeed, their phantasies were less aggressive, as well as less sadistic:

"I don't imagine harming people. All I do is I want to defend myself… if, for instance, someone threatens me for violence I will stand up 'Come in I will fucking fight you'. And if that doesn't work and the person attacks me, I will try to fight back. But I don't sit there and think about somebody… any reasons why I don't like him or why I want to hurt him… I am not… I don't do that."

(MEIGV64)

"Usually my first response would be if I was angry with someone to try to talk about it… Try to find a way to resolve this without being violent."

(MEIIV31)

"If I am angry with someone… excuse my French here but I tell them to piss off in a very aggressive manner."

(CLLSH36)

"I just walk to my room. And I say to them we will talk when you calm down. Come and speak to me later. You know I will be here for you. Let's support each other. There is a better way to do it."

(CLDWG54)

Two patients were more open and revealed the violent content of their fantasies:

"I want to hurt them. My mind blocks out. I don't think, I just want to hurt."

(CLDEC49)

"I feel like hurting them. But I don't. It is just in my mind."

(MEICR35)

With regard to the frequency of their fantasies, most non-sadistic psychopaths admitted that they did not experience violent fantasies often:

"Not often. Not very often. Every now and then. Not too often. If something doesn't go in my way, when I feel like people working against me, when I am paranoid… you know."

(MEICR35)

"Very rare. As I said the last ten years not violence at all."

(MIIV31)

Several patients said that they only had violent thoughts when they re-experienced a past trauma, or when they had to be violent towards people:

"Only when I have to be violent towards people… It is not part of my mind to be thinking about violence."

(MEIGV64)

"Let's say a couple of times a month. It depends on trauma, on what my problems are. Because you got to remember that trauma is coincided with violence. I am trying to calm myself down and things like that. Do I think of violent thoughts? No. Am I angry all the time? No…. It is usually for me… flashbacks, trigger words… when people live in my place…"

(CLCBV53)

There was only one patient who said he was experiencing 'sinister' fantasies all the time:

"I have aggressive thoughts all the time… I have thoughts on… what's the word… Hm… I have sinister thoughts. Forbidding thoughts. Evil thoughts. Violent thoughts. I can't explain it. It is like I see things happening and I want to put a barrier up. Like a buffer zone. My own buffer zone."

(CLDEC49)

Theme 5: Victim-perpetrator dynamics

The psychopathic symbol formation in sadistic psychopaths

Another important theme that arose during the interviews was the relationship between the psychopath and their victims. The analysis revealed that a psychopath's victims seem to have a symbolic significance to them. All the sadistic psychopaths' victims were known to them. They were either partners, family members, friends or acquaintances. They were people who the sadistic psychopath had an intimate relationship with. This finding indicates that there appears to be a relational element in sadistic violence within the construct of psychopathy. This finding is in contrast to previous findings (e.g. Meloy, 2006; Robertson & Knight, 2014), which suggest that the nature of sadistic violence is primarily instrumental. Thematic analysis indicates that the function of sadistic violence was reactive, as well as relational, at least within the current sample of participants. The narratives reflect that on most occasions, the victim was actually very important to the perpetrator, as they had a symbolic representation for them.

One patient, whose index offence was rape, described what happened prior to the offence and how he felt during the offence:

"So, it was like it built up over time and exhibit different behaviours to people around me… phantasies happened, and I had a stronger urge to basically commit a sexual offence. It was during college that I came with this idea to rape… So, I eventually did it. She was a teenage girl I got involved with… During the offence I was half and half… I didn't want to be there or commit the offence… I was pretty aware of what I was doing… I was acting upon a phantasy… but in reality, with an actual person. I was fighting myself to stop… but I committed the rape… It was really difficult. I think I was in control of the situation. I wasn't trying to demonstrate to the woman I assaulted I was not in control."

(CLAVG47)

When the same patient was asked what the victim represented for him, he said:

"What I would say is that during phantasy victims tend to be my age, so at the time of my first offence, I was 17 so that was the age group I was looking at. But it was like it was happening over the days building the courage to commit the offence. The offence lasted for 30-45 minutes, something like that."

(CLAVG47)

Amongst the victims of another patient was his ex-wife, and woman who he had a relationship with and who he raped as well:

"I got down against my ex-wife for domestic abuse… What I didn't tell you was that I was also convicted for a rape. It was one of the times that I met up by accident with a lady that came over to me. And there was a massive explosion at the moment. By 2 o'clock in the morning, I drunk 5 bottles of Jack Daniels. The offence occurred. Genuinely, I got no memory of the offence."

(MEIGF53)

When asked how he felt during the offence he said:

"I don't have physical memories... what I read in the statement horrified me… And it still horrifies me to that day. It's fucking horrible."

(MEIGF53)

Another patient described how he tried to kill his daughter's boyfriend by setting fire to his house because he was abusing her:

"I was looking for him. This time I wasn't listening anymore. I wanted to hurt him. When I got to the house there was no one there. I went to his dad's house. I kicked the door, I saw the mother and the father and I said to them I don't care for you anymore. I lost all feeling and emotions I had nothing. I just wanted to assault him. I just wanted to hurt him for what he did. My mind when I got at his home said 'He is worthless, he does not deserve anything.'. So, I set fire to the rubbish at the house to destroy everything he had – he had nothing. I

didn't take into consideration other people that lived next door or the next houses. Luckily no one got hurt."

(MEIFR52)

A sadistic psychopath who sexually abused two children, 6 and 9 years old, said:

"At the time I didn't really think anything. Afterwards you think. Why I have done it? I wish I was dead at times… I would rather be dead than doing something like that again."

(CLCCO38)

Other patients' victims were authority figures, like the police:

"My aggression was directed towards the police. I never liked them. I never had a good relationship with the police."

(CLBOW38)

The psychopathic symbol formation in non-sadistic psychopaths

An important difference in victim selection and symbolic representation between sadistic and non-sadistic psychopaths was that the victims of the non-sadistic psychopaths

were not known to the perpetrator and there was no specific motivation in committing the offence.

A patient who was convicted for murder described his offence as follows:

"On the day of the index offence I was going through a really hard period of time in my life… no money, no girlfriend, no job, in and out of the psychiatric units, I wandered, I just flipped, turned around and pushed this guy in front of the train… sadly that was the thought I had in mind. Another reason I did it was because that particular person was closest to the train… he was close to the track. He was in the platform but was really close, so when the train was coming, I pushed him and then… since then I never been violent. So, the quality of my life at that moment was very frustrating. *I was angry not just with people but also with myself as well – I think I was more angry with myself that with anyone else... which led me to lose control. The person was a total stranger to me I did not know him."*

(MIIV31)

A few patients, however, had a more intimate relationship with the victim and their offences had a lot of sadistic elements:

I got involved with a Polish woman. We were teamed up as working partners. We got into a sexual relationship quite quickly. It was very… very fiery and unbeneficial relationship. We were always fighting and arguing, and I went to her flat one day and on another sense we should have met… And I coerced her in the sitting in the car with me… and then we went to my flat… I said I had enough of you… you really took the piss out of me… I am gonna show you what I think about you... No clothes were taken off I just bend her over on the sofa and

pretended I was having sex with her saying 'this is what you like blah blah blah…' And then I calmed down, we had a cup of tea and I took her back to her flat. I said I will see you tomorrow and she laughed at me and said you are so stupid. I know exactly what it means now retrospectively. At that time I thought it was part of the relationship and we were still in the relationship even though it was what it was the only think I did at that time… but I was in a really bad space, you know. It was not a nice situation… Well I suppose it's all wrong."

(MEIGV64)

When the patient was invited to share his feeling during the offence he said:

"I just wanted her to feel how I felt. She really let me down and I felt really bad about it. I didn't want to end the relationship, I wanted her to think about it. As I say no clothes were taken off, there was no penetration. I finished all about it now…."

(MEIGV64)

"I assaulted a pregnant doctor… I don't remember that. If that was true, I would have been sent to prison, if not Broadmoor… She claimed she had a miscarriage… I was extremely angry and became paranoid. I just wanted to hurt her. I was going mad. I was crying all the time. I didn't want to stay in the psychiatric unit. I still feel that though."

(CLDEC49)

Another patient claimed that he attempted to murder, out of envy, a young child who he had a very close relationship with because he reminded him of his dead brother:

"My index offence was GBH on a 4-year-old. But I am actually ashamed of. My little brother died when I was 7. That was a very traumatic thing on me. On an any 7-year-old child. Before committing the offence, I have been drinking a lot… Before the offence I had a lager and then whiskey on top of it. I had 3 whiskies. So, I really was quite tipsy. And that child entered the room… and for some reason I don't know why… I can't figure out why… all of the sudden I saw my brother's face and I was so angry for leaving me. I just lost it completely. And I jumped on L., I punched him... kept him… I tried to strigulate him and in the end, he was like (sounds like someone is drowning). He was unconscious. I thought he was dead. I was 21-22 years old at that time. The boy was 4."

(CLLSH36)

When he was asked why he chose him he said:

"I don't know why I chose him. He followed me all the time. And there were times when I protected him. His older brother M. hurt him sometimes and I stood in the way to protect him. And I said to M. 'No you are not touching him'… 'If you touch me you need to go through me first'. I had a good relationship with him. Whenever I went L. was right behind me. There were times when I was asleep, and I could feel something in the bed… and I thought 'What's that?' I woke up and L. was there. I was like 'L what are you doing here?' And I put him back to the bed. L was my niece's little brother. The youngest. He reminded me of my little brother. Because me and my little brother had a very good close relationship. We did everything

together. It really had a traumatic effect on me when he passed away. He died in a, as I say, it was not done, he died in an emergency theatre 3 o'clock in the morning."

(CLLSH36)

5.3 A reflective note on my research journey

5.3.1 Introduction

I find it difficult to believe that three years have passed since this research started. The aim of this thesis was to theoretically and empirically investigate the psychopathic and sadistic personality, and particularly the early environmental factors that contribute to the development of psychopathy and sexual sadism. My personal motivation was to understand the psychopath's and sadist's internal world and interpersonal dynamics using the conceptual tools of object relations theory and attachment theory. My intent was to explore whether, and how specifically, those early developmental antecedents are associated with severe forms of aggression and sadism.

This, however, was far from being an easy task. Indeed, my research journey into the abyss of the psychopathic and sadistic mind was difficult as I encountered many challenges along my way. In this section, I will attempt to revisit my research providing a reflective account of my research journey, before turning to discuss and interpret the findings of my study. The challenges I encountered throughout this journey considerably contributed to my own personal development as a researcher, but also as a human being.

No development, however, comes without failures, mistakes and discomfort. Or, as Nietzsche would have added, 'The more he (a man) seeks to rise into the height and light, the more vigorously do his roots struggle earthward, downward, into the dark, the deep – into

evil' (Nietzsche & Kaufmann, 1995, p.47). During the past three years, I often found myself 'wrestling in the dark' as the research work with psychopathic and sadistic patients triggered my most intense emotional reactions, emotional reactions that I had to manage, tolerate and, most importantly, to understand as they unconsciously affected my interpretation of the results.

5.3.2 Securing access to secure hospitals and prisons in the UK

A problem facing researchers working in secure hospitals and prisons is that access to these settings can be difficult and time-consuming. This was no different in my case as I had to seek approval from the NHS Research Ethics Committee, the Health Research Authority (HRA) and the National Research Committee at HMPPS. At the first stage of my research, I had to obtain approval from the Queen Mary University Joint Research Management Office (JRMO) that agreed to act as a sponsor for my study.

I subsequently started preparing an application for the NHS ethics committee through the Integrated Research Application System (IRAS), which was a long and challenging process. Despite the efforts to speed up the process, it took considerable time. In terms of security clearance, I had to undertake an enhanced Disclosure and Barring Service (DBS) check. I submitted my application to the IRAS on March 2017 and I was invited to an interview by the East Midlands - Leicester South Research Ethics Committee on May 2017. I received the official approval letter in August 2017.

Once all the necessary ethical and security checks had been carried out, and prior to any data collection, I had to undertake a three-week intense induction and security training at Broadmoor Hospital, which was the only site I had included in my application at that time. This was an essential process for the entire endeavour as I had no experience working in a forensic setting and I was unaware of the dangers that it involves. I was required to attend various training sessions about: security; management of keys; diversity awareness; policies

and procedures; health and safety; fire safety and most importantly, breakaway and management of violence and aggression. Once the three-week induction was completed, I was issued with key access to the hospital and an identification card.

When my training came to an end, I arranged an introductory meeting at Broadmoor Hospital with one of the clinical leads. Although these meetings can be helpful as they facilitate the familiarisation process, things did not work well for me. I was informed that many things had changed since the old DSPD days and the personality disordered population in Broadmoor is considerably smaller compared to the situation a few years ago. I was made aware that there were not more than 10 patients in the hospital who met my inclusion criteria, as most of them also had a diagnosis of a mental illness and they were not able to consent.

I subsequently contacted other lead clinicians in medium security hospitals within the country and set up introductory meetings with them in order to identify units that may have suitable populations for my study. I included four medium security units within the NHS, as well as one personality disorder unit within prison. This, of course, took a considerable amount of time. Inductions, security training and introductory meetings with staff and patients took place at each site prior to data collection.

Once I had been issued with ID for each of the units, I had to further negotiate access to hard and/or electronic files and bring a digital recorder for the interviews. I had to adhere to each site's policies and procedures and I quickly realised that negotiations may continue on a regular basis. One of the ongoing challenges I faced, however, was the change of staff. Staff change had an impact on my research work, as some of them experienced me as an 'intruder' and I had to develop trust with them. This was problematic as it generated the need for more introductory meetings that caused further delays in the study.

Despite the initial difficulties which caused significant delays in my study, recruitment went relatively well. Overall, 56 forensic mental health patients and 6

incarcerated offenders consented to take part in the study. Although the recruitment went well and the patients appeared keen to participate, it took a long time for the questionnaire battery to be completed. This was due to many reasons. Patients were often unwell or there was upheaval in the ward. Several patients found it difficult to complete the questionnaires as the questions 'brought up stuff from the past'. Most of the patients were also keen to participate in the second phase of the study, so there were no particular difficulties during the interviews.

5.3.3 Data handling and impression management

Another significant challenge I faced during the data collection period was the access to collateral and medical information. Despite the technical difficulties that occurred frequently, I quickly realised that a lot of information was missing. On a few occasions I was only able to find preliminary assessments and total scores but not comprehensive reports. For example, I had to rely on the existing, clinician-rated classification criteria for all four facets of the Psychopathy Checklist-Revised (PCL-R) to obtain a psychopathy diagnosis; however, only the PCL-R total score was reported. Indeed, it was a challenge to try to establish a dataset on 59 patients as the quality and availability of data varied considerably.

The management of my self-presentation was very important during the study. As a young male inexperienced researcher, I was always considering how my background and limited experience was perceived by the patients and staff and how it may have influenced my data analysis and interpretation. As a non-native English speaker with a south-European accent, I was aware that this may have an impact on patients and staff as I was already a 'foreigner' in the unit.

Although I don't think that my age and nationality generated significant difficulties, some patients treated me with more suspicion than others. On several occasions, I experienced some interrogation by both staff and patients who were asking me where I was

from, who my supervisor was or why I was doing the research. Most of the patients and staff, however, were very supportive of me and I am indebted to them.

5.3.4 Managing my countertransferences

The most difficult challenge I faced during this study was the management of my own countertransferece reactions within the secure settings. Although the psychoanalytic term 'countertransference' has been often interpreted differently in the literature, it is best defined as the therapist's emotional responses to the conscious or unconscious material that the patient brings (Greenson, 1974). Although there is always an endogenous dimension of countertransference, most common to clinicians who work with psychopathic and sadistic patients is the so called "reactive dimension" (Meloy, 2002).

The reactive dimension refers to the therapist's responses to a patient's preverbal communication, which is often a re-enactment of the patient's relationship with his significant others (Meloy, 2002). Countertransference, however, does not include the totality of reactions to the patient as there is also a real relationship between the two. Nevertheless, it is argued that real relationships are absent in psychopaths, where a state of nonrelatedness predominates. Reid Meloy (2002) and Otto Kernberg (1980, 1991) identified key countertransference responses to psychopathic individuals.

I experienced very intense countertransferences prior to as well as during my research journey. On 6 of June 2017, I was driving for the first time to Broadmoor Hospital. While I was driving, I experienced intense feelings of excitement and euphoria. My overenthusiasm, which was equally composed of naivete and inexperience went away when I first saw the walls of the hospital. The feelings of excitement quickly turned into intense anxiety and fear and I started experiencing dysphoria. Fortunately, I started feeling afraid.

My emotional reactions that arose through my interaction with psychopathic and sadistic patients were far more intense and primitive. I did experience two ostensibly

different, but very primitive countertransference responses during my interaction with psychopathic and sadistic patients who had committed heinous crimes. When I was reviewing their criminal files, going deeper into the very details of their crimes, I experienced intense hatred and rage. On a few occasions I was not even able to finish their criminal histories due to very intense emotional reactions I had. I did manage to go back and finish them, however, I found it really difficult. I quickly realised, however, that my feelings of rage came from an unconscious identification with the patients' victims and they were a response to my own feelings of helplessness which were triggered throughout my research work with these patients.

The second countertransference reaction I experienced occurred during my actual interaction with patients during the interviews. When the patients were revealing to me information about their early relationships with their primary caregivers, I started feeling sympathy towards them. Given my Greek background, I feel that I have to include a linguistic note here. The Greek word 'sympathy' originally means 'suffering together' and it denotes an individual's capacity to enter into another person's emotional world and understand them. In some ways, it is a synonym for empathy. This depicts how I felt when the patients were describing to me how severely they were abused and how helpless they felt in their childhood. My feelings of sympathy were the product of another concordant identification: the identification with the psychopath's internalised beaten child.

On many occasions, I experienced an atavistic fear of assault from the patient. Countertransference fear of the psychopathic and sadistic patients is considered as a primitive response to the predatory nature of their personalities (Meloy, 2002). Although the countertransference fear is considered as a complementary identification, I learnt that we should not rule out the possibility of real danger. Indeed, they can both coexist.

Having therapy three times per week helped me to contain and most significantly integrate all these primitive emotional responses that arose during my encounter with the psychopath and the sadist. By understanding my own emotional responses, I was better able to dive into the psychopathic mind. Being able to separate what was mine and what was the patients' response probably reduced my bias and led to more objective interpretation of the results.

CHAPTER SIX

DISCUSSION

6.1 Introduction

The constructs of psychopathy and sexual sadism have a long history in psychiatric literature. Research has shown that both psychopathy and sexual sadism have been linked theoretically, clinically and empirically to sexual offending and sexual homicides (Darjee, 2019; Knight, 2010; Knight & Guay, 2006), as well as to non-sexual violence (Porter & Woodworth, 2006). Whereas psychopaths are committed to aggression for its own sake and pursue hostility as an end (Juni, 2010), sexual sadists have been shown to derive enjoyment and sexual excitation from the physical and emotional suffering of their victims (Stone, 2010). They both, however, require interpersonal aggression as part of their own regular emotional experience.

Despite the theoretical and clinical association between the two constructs, as well as their correlation with violent behaviour, only very few studies have attempted to explore their interface (Darjee, 2019; Holt et al., 1999; Mokros, Osterheider et al., 2011; Robertson & Knight, 2014). Thus far, those studies that have sought to explore the interrelation between sexual sadism and psychopathy have suffered from poorly operationalised definitions and limited assessment of sadism; and failure to consider the interpersonal experience of psychopathic and sadistic individuals.The current mixed-method research sought to remedy these issues by using validated measures of sexual, as well as trait sadism, and by conducting interviews in an attempt to assess the interpersonal experience of each participant.

Although we have just begun to understand the interface of sexual sadism and psychopathy, the aetiology of both constructs remains largely unknown. In addition, psychological treatments for psychopathic and sadistic patients are marked by therapeutic

pessimism and the two constructs have been deemed amongst the most treatment-resistant syndromes in clinical psychopathology.

This study represents an effort to empirically explore the developmental antecedents and aetiological pathways that contribute to the development of psychopathy and sexual sadism. Drawing from the psychoanalytic theory, it was hypothesised that sadism is a severe manifestation of hostile psychopathy (Juni, 2009, 2010). Considering this hypothesis, the primary aim of the study was two-fold: first, to investigate the early environmental antecedents that could potentially explain and predict psychopathic and sadistic behaviour in a forensic mental health population of violent and sexually violent participants, and to explore the extent to which those antecedents impact upon adult personality development in individuals who are psychopathic and sadistic; second, this thesis sought to provide further empirical evidence with regard to the relationship of two of the most controversial constructs of our time.

The following discussion will begin with a review of the methods used to measure each construct and then proceed to present the major findings, first with regards to the relationship between psychopathy and sexual sadism and, second, on the contribution of the early developmental antecedents of both constructs.

Table 17
Comparison of qualitative and quantitative findings

	Quantitative findings	Qualitative findings
Association between psychopathy and sexual sadism	• Sexual sadism related to psychopathy • Sexual sadism predicted psychopathy • Trait sadism significantly associated with psychopathy • Sexual sadists presented higher psychopathy scores than non-sexual sadists	• Sadistic psychopaths displayed more savage aggression comparing to non-sadistic ones. • Aggression in sadistic psychopaths had considerably more sadistic elements • The function of sadistic aggression appeared to enhance psychopath's grandiosity and omnipotent control over his victims
Early traumatic experiences in psychopathy and sexual sadism	• Exposure to trauma during early childhood is associated with the development of more severe sadistic and psychopathic traits • Adverse experiences were associated with sexual sadism • Sexual sadists scored higher on TEC comparing to non-sexual sadists • Psychopaths scored higher on TEC comparing to non-psychopaths • Sexual abuse predicted sexual sadism • Trauma predicted psychopathy • Psychopathy was particularly correlated with emotional abuse	• Sadistic and non-sadistic psychopaths experienced the following traumatic experiences: neglect; parental humiliation; psychological abuse; Helplessness; and foster home placements • Sexually sadistic psychopaths experienced more severe trauma • Sadistic psychopaths' maternal object appeared to be abusive and neglecting, whereas non-sadistic psychopaths described it as cold and distant • Sexual abuse and harassment were particularly relevant to sexual sadism
Attachment abnormalities in psychopathy and sexual sadism	• Sexual sadism negatively corelated with attachment avoidance and secure attachment • Secure attachment negatively correlated with psychopathy • Sexual sadists were more dismissing	• Sadistic psychopaths related to their victims on basis of omnipotent control, power and domination • Non-sadistic psychopaths behaviour seems to be characterised by emotional detachment

	comparing to non-psychopaths • Sadistic psychopaths were more dismissing comparing to non-sadistic ones	• Sadistic psychopaths appear to be more preoccupied than non-sadistic • Sadistic psychopaths displayed ego-syntonic predatory fantasies prior to the offence
Narcissistic traits in psychopathy and sexual sadism	• Psychopaths were more narcissistic than non-psychopaths • Narcissism predicted sadistic traits	• Grandiosity and omnipotence were evident in both sadistic and non-sadistic psychopath's narratives • Patients' narratives reflect narcissistic traits

6.2 The relationship between psychopathy, sexual sadism and trait sadism

6.2.1 Measurement of the constructs

As was discussed in Chapter 2, psychopathy was measured using Hare's (1991) Psychopathy Checklist Revised (PCL-R) which is considered the gold standard for analysing psychopathic traits in forensic populations. The assessment of psychopathy was based on the existing, clinician-rated classification criteria of PCL-R and/or the Psychopathy Checklist: Screening Version (PCL:SV; Hart, Cox and Hare, 1995). There were three main reasons behind this decision. First, the researcher was not qualified to administer the entire PCL-R that includes the semi-structured interview; however, he was trained to screen patients' file information for psychopathy using the PCL-R/PCL:SV. Although it is argued that it is possible to obtain a PCL-R rating solely based on file information, the material gathered during the semi-structured interview is a very important part of the assessment that significantly contributes to the psychopathy diagnosis. According to Hare (2003), there are difficulties in providing an accurate assessment of psychopathy when the assessment of psychopathy is exclusively based on archival ratings, due to observer bias (Hare, 2003).

Secondly, should the researcher have screened patients' files, this would have required more administration time that would subsequently have caused severe delays to the project. Third, the researcher was not experienced enough in assessing psychopathy using the PCL-R/PCL:SV and that would have potentially affected the accuracy of psychopathy scores. To avoid the risk of misdiagnosis and given the difficulties in the assessment of psychopathy, using a rating derived from a trained and well-experienced clinician was considered to be the most appropriate decision contributing to the accuracy of the findings.

It is unfortunate that the researcher was not able to obtain any facet scores of the PCL-R for most of the patients. Patients' medical information only reflected a total PCL-R / PCL:SV score without including any facet scores. This did not allow any comparison between PCL-R Interpersonal and Affective facet scores one the one hand, and sexual sadism on the other. Sadism was assessed using more than one measurement technique, namely the SESAS and the ASP. The first was designed to measure severe sexual sadism in clinical/forensic populations, while the second (ASP) was initially designed to measure sadism in non-clinical populations. The ASP is a short 20-item measure that reflects most of the characteristics of the sadistic personality disorder categorised in three major groups of traits: subjugation, pleasure seeking and lack of empathy.

Furthermore, there has been debate over whether sexual sadism is a single diagnostic entity or if there exist different manifestations of sadism. Because of continued debate over the definition of sadism, it is unclear whether sexual sadism can be considered as a separate construct from other forms of sadism, namely sadism as a personality trait or as a disorder of personality (Krueger, 2010). Drawing on psychoanalytic theory, we argue that sadism is best conceptualised as a severe endogenous character pathology and a core personality trait. Given the theoretical stance of this thesis, the ASP was chosen as an appropriate instrument, because

it is short, easy to administrate and most importantly because it reflects most of the sadistic personality disorder core traits.

6.3 Summary of the main findings

6.3.1 Psychopathy and sadism

Generally, the hypotheses of the study about the relationship between sadism and psychopathy, namely i) sexual sadism will be significantly associated with psychopathy, ii) sexual sadists will have higher psychopathy scores compared to non-sexual sadists, and iii) trait sadism will show a significant association with psychopathy, were supported by the results, both with regard to the replication of findings from previous studies (Darjee, 2019; Holt et al., 1999; Mokros et al., 2011; Robertson & Knight, 2014; Holt, Meloy and Strack 1999) and also with regard to previously untested hypotheses, at least in the current sample of participants.

The results indicate a strong, positive correlation between sexual sadism and psychopathy, supporting Hypothesis 1. This finding is in accordance with Mokros et al. (2011), as well as Robertson and Knight's (2014) study, who found that there is a significant covariation between the two forensically related constructs. It was expected that sexual sadists will present considerably higher scores on the PCL-R compared to non-sexual sadists. Indeed, the results suggest that sexually sadistic participants were considerably more psychopathic than the non-sexually sadistic participants. Bivariate analyses showed that significant positive correlations were also found between the PCL-R total score and ASP, suggesting that psychopathy is significantly associated with trait sadism. This finding raises an important question: are psychopathy and sexual sadism different constructs, or can sexual sadism be considered a subtype of psychopathy?

Regression analysis showed that sexual sadism predicted psychopathy, whereas trait sadism was not a strong predictor of the construct (see Chapter 4). Furthermore, almost all the sexually sadistic patients in this study were diagnosed with psychopathy. Specifically, 14 out 15 sexually sadistic participants scored ≥ 25 on the PCL-R. By the same token, only 15 out of the 29 psychopathic patients were classified as sexual sadists. These findings led us to speculate whether there exists a distinct subtype of psychopathy, namely sadistic psychopathy. Previous research has shown that psychopathy and sexual sadism are distinct but interrelated constructs (Mokros et al., 2011), whereas psychoanalytic researchers have suggested that sadism is a severe form of hostile psychopathy (Juni, 2009). The findings of the quantitative part of this study, however, appear to support the psychoanalytic hypothesis, suggesting that sadism is a severe manifestation of psychopathy.

Findings from the qualitative interviews provide further support to the hypothesis of the existence of sadistic psychopathy as an extreme form of the disorder. Fromm (1973) conceptualised sadism as the derivation of pleasure that comes through the subjection, domination and control of others. Forcing another human being to suffer pain without the option of escape is the ultimate expression of triumph coming from the total domination over the other person. Most salient to the psychopath is his predisposition to predatory violence, a mode of aggression that is consistent with his callous, remorseless and unempathetic attitude towards other people.

Interview narratives indicate that sadistic psychopathy captures the personality pattern of a psychopath who gets intense pleasure from this type of aggression. Sadistic psychopaths related to their victims on the basis of power and omnipotent control. As a sadistic psychopath said to me: *"I can only say the way I feel it and I don't expect you to understand that. It's easier in an environment surrounded by violence 24/7 and all you have around you*

are violent offenders, and a lot of them are violent prison officers… the only way to survive in the jungle is to be the king of the jungle."

The same patient revealed to me that he was recognised as 'one of the most violent individuals in the prison system'. Being the 'most violent' and 'the king of the jungle' reflects the psychopath's grandiose self-structure which can only be maintained through the sadistic control and behavioural devaluation of their victims. The same patient described the pleasure he experienced when he intimidated one of his fellow patients, who attempted to challenge him.

Indeed, aggression in psychopaths who displayed more sadistic traits, and particularly in those ones who were also exhibiting sexually sadistic behaviours, had considerably more sadistic elements. The feeling of pleasure that derives from the hurt and humiliation of another human being, however, appeared to be secondary to the psychopathic aggression and on most occasions, was not even present in the patients' narratives, unless they chose to conceal it.

Thematic analysis of the interview transcripts revealed that the primary aim of the sadistic aggression within the construct of psychopathy was two-fold: first to enhance the sadistic psychopath's grandiosity and omnipotent control over his victims and, secondly, to protect his vulnerable and fragile psychological self by aggressively keeping the internalised 'beaten child' safe and sound. The two functions of aggression within the construct of sadistic psychopathy, however, are not mutually exclusive but they are inevitably linked to each other.

Psychopaths' need to maintain their narcissistic equilibrium and omnipotent control over their victims was present in the interview narratives: *"I was pretty aware of what I was doing… I committed the rape… I think I was in control of the situation. I wasn't trying to*

demonstrate to the woman I assaulted I was not in control". This quote reflects the sadistic psychopath's need to exercise omnipotent control over his victim who he subsequently raped. The reactive nature of a psychopath's aggression as a means of protecting the internalised beaten child was also notable in patients' narratives: *"All I do is I want to defend myself… if, for instance, someone threatens me for violence I will stand up 'Come on I will fucking fight you'. And if that doesn't work and the person attacks me, I will try to fight back."*

As discussed in Chapter 2, psychopaths function at a borderline level of personality organisation (Kernberg, 1984) or its corollary, the paranoid-schizoid position (Klein, 1946). Psychoanalytic research has shown that the most frequently used psychological defences in psychopathy are splitting, projective identification, devaluation, omnipotent control and denial (Gacono and Meloy, 1992). The aim of these defences and manic controls is to ameliorate persecutory anxieties. These persecutory anxieties, in our view, are derived from the internalisation of a 'predatory paternal object' and an '(un)dead mother'. The internalisation of such cruel parental objects threatens the sadistic psychopath's self and they desperately try to ward them off by projecting them onto other people.

6.3.2 Narcissistic traits in Psychopathy and Sexual Sadism

To survive in such a hostile internal world, the sadistic psychopath must build a narcissistic, pseudo-autonomous personality structure, namely a 'grandiose self-structure' (Kernberg, 1975). This intrapsychic pattern was very evident in the participants' narratives. A sadistic psychopath's grandiose self-structure reflects a malignant, omnipotent and cruel world of internalised object relations. The psychopath is sadistically enslaved in this persecutory internal world, the grandiose self-structure, which is the 'product' of his early identifications with the aggressive parental objects. This aggressive internal world, dominated by sadistic self and object images, was illustrated in a very lively way in a psychopathic patient's recurring nightmare. The patient dreamt that he was being chased by predators such

us sharks, tigers and lions. He conveyed to the researcher that he felt utterly helpless when he had those nightmares and that he would wake up in the middle of the night screaming for his mother.

The quantitative results of the study appeared to only partly confirm the underscored centrality of narcissism in psychopathy and sexual sadism. Narcissism was measured by using the shorter version of NPI, namely the NPI-16 as it was quick and easy for this group of patients to complete. The NPI-16 reflects significant core narcissistic trait characteristics of the narcissistic personality disorder. The NPI-16, however, demonstrated poor internal reliability. It is hypothesised that the low value of alpha was the result of a low number of questions. In contrast to the theoretical and clinical assumptions, no consistent pattern of relationships among the constructs emerged across the measure. Narcissistic traits were not associated with either psychopathy or sexual sadism, but they were found to positively correlated with trait sadism.

Psychopaths, however, were found to be significantly more narcissistic compared to non-psychopaths. This finding is in accordance with earlier studies that have previously tested the relationship between psychopathy and narcissism (Gacono & Meloy, 1994; Fossati et al., 2014; Paulhus & Williams, 2002; Gacono et al., 1990). In constrast to expectations, no significant differences were found in the mean scores of narcissism between sexual sadists and non-sexual sadists, as well as between sadistic and non-sadistic psychopaths.

Regression analysis has further showed that only trait sadism was useful in predicting narcissism. This finding may indicate that violent and sexually violent participants with more severe sadistic traits are presenting more severe narcissistic traits as well. The correlation between ASP and NPI-16 may also be related to the fact that both questionnaires were designed to measure sadistic and narcissistic traits in non-clinical populations. It is possible,

however, that criminal psychopathy and severe sexual sadism are associated with more severe forms of pathological or aggressive narcissism which were not captured by the NPI-16.

The t- tests and bivariate analyses seem to indicate what psychoanalytic researchers and clinicians postulate, that narcissism is central to psychopathy but alone insuficient to aetiologically explain the disorder (Meloy, 2002; Kernberg, 1989). Narcissism is not a developmental antecedent of psychopathic personality, at least within the current sample of participants. This finding supports what was thus far clinically observed: that narcissism is a core trait but not a developmental hallway to psychopathy.

This also replicates findings of previous psychoanalytic research which has suggested that narcissism alone is insufficient to aetiologically explain the psychogenesis of the psychopathic personality (Meloy, 2005; Gacono et al., 1990). Most salient to sexually sadistic psychopaths appears to be a specific type of narcissistic personality which is characterised by exhibitionism and masculine striving, namely the 'phallic-narcissistic character' (Reich, 1933). Due to severe childhood frustrations and lack of love and affection from the mother, the 'phallic-narcissistic psychopath' exercises sadistic revenge over the sexual object. As a sexually sadistic psychopath convicted for rape said: *"I just wanted her to feel how I felt. She really let me down and I felt really bad about it. I didn't want to end the relationship, I wanted her to think about it."*

It is argued that the sexual object chosen is reminiscent of the psychopath's (un)dead mother, a key player in his primary trauma. Arguably, it can be understood as a case of transference, and more specifically of a malignant mode of repetition compulsion. We named this malignant mode of narcissistic repair and repetition compulsion 'The Murder of Clytemnestra'. We will further elaborate on this in Section 6.3.3.

Although there are several intrapsychic differences between psychopaths and pathological narcissists, psychopathy is mainly distinguished from narcissistic personality

disorder or pathological narcissism by the behavioural devaluation of others. This is in contrast to the devaluation of others in fantasy that occurs in narcissistic personalities. In contrast, the psychopath has to behaviouraly devalue others to maintain his grandiose equilibrium, which constitutes a malignant type of narcissistic repair compared to a more benign one used in other narcissistic pathologies (Kernberg, 1984). The psychodynamics of a psychopath's malignant narcissistic repair are consiously and unconsciously experienced through envy and hatred when he does not get what he thinks he is entitled to receive (Meloy, 2005).

Indeed, patients' narratives appeared to confirm that both sadistic and non-sadistic psychopaths display aggressive behaviour when they do not get what they believe they are entitled to receive. Qualitative interviews revealed that several psychopathic patients became physically violent towards medical staff and their fellow patients when they did not follow their demands or when they felt small and humiliated. It is unclear what is causing the failure of the function of fantasy in psychopathy; however, it appears that psychopathic participants cannot repair emotional wounds through fantasy and by devaluing the object in their mind. A careful examination of psychopaths' internal worlds, as manifested through their violent fantasies, will potentially shed some light on why these patients are unable to engage in more benign modes of narcissistic repair.

6.3.3 The function of fantasy in psychopathy and sexual sadism

Fantasies are particularly important in understanding the internal world of the sadistic psychopath. Most of the sadistic psychopaths experienced aggressive fantasies prior to the violent acting out of these fantasies in actual behaviour. One of the most important characteristics of those fantasies was that they were mainly ego-syntonic; psychopaths did not appear to experience any feelings of anxiety or dysphoria while they were revealing the very violent content of their fantasies. These dynamics were very present in the patients' quotes.

Instrumental aggression and raw violence were central to sadistic psychopaths' fantasies. Their predatory fantasies reflected homicidal feelings ranging from simple violent acting out (punching, kicking, grabbing by the neck) to more sadistic modes of aggression (such as taking someone's eyes out with a pen). Other patients conveyed to the researcher that they were constantly thinking of taking revenge, whereas others said that they did not have time to think of anything; they just act out. It is argued that the need for revenge shapes the content of the sadistic psychopath's fantasies. Interestingly, the sadistic psychopath's predatory fantasies are not directed towards strangers, and there appears to be a link between intimacy and violence in their fantasies. This could be psychodynamically rooted in psychopaths' primitive object relations nature, and more specifically in their own feelings of envy.

It is not surprising that sadistic psychopaths did not divulge sexually violent fantasies. Patients who committed sexually violent offences were very reluctant to reveal the content of their fantasies. There was only one participant who admitted that he had sexual phantasies. This patient, however, said that sexual fantasies ameliorate his anxiety and help him to cope with feelings of anger and rage, although 'they are not always working and can become more external'. In such a case, sexuality is intertwined with aggression, as happens in sexual sadism; the dynamic understanding of their congruence, however, is difficult to elaborate.

A non-sadistic psychopath's internal world, as manifested through their fantasies, appeared to be less violent. Indeed, their fantasies were less aggressive, as well as less sadistic. Furthermore, they seemed to experience intense anxiety when discussing the content of their thoughts. This may indicate that fantasies of non-sexually sadistic psychopaths, as well as psychopaths with fewer sadistic traits are more ego-dystonic. This, of course, was not the case with sadistic psychopaths who seemed very comfortable elaborating on the predatory nature of their fantasies.

Sadistic psychopaths experienced aggressive fantasies much more frequently compared to non-sadistic psychopaths. Some sadistic psychopaths said that they experienced violent fantasies when they were not respected, whereas non-sadistic psychopaths' fantasies appeared to be triggered by past trauma.

It is argued that the pain inflicted on the object in psychopathic fantasies is of great importance and the perception of it enhances the psychopath's feeling of pleasure and control over the object. Hate and revenge are the primary affective states triggered by such fantasies. These predatory fantasies, however, fail to alleviate the psychopath's internal state of mind and to act as a defence against instinctual impulses and persecutory anxiety. The question then arises at this point as to why psychopaths cannot repair emotional wounds and ameliorate persecutory anxieties by devaluing the object of the felt or anticipated humiliation in their fantasy.

From a dynamic viewpoint, it is hypothesised that fantasy alone is insufficient to contain the psychopath's persecutory anxieties. The psychopath cannot simply ward off those internal states by attacking the threatening object in fantasy. As proposed earlier, such anxieties derive from the internalisation of cruel parental objects, namely the father-predator and the (un)dead mother. It is further argued that the specific pathology of a psychopath's internalised moral systems and a specific deterioration of their world of internalised object relations facilitates the acting out of such fantasies.

The findings of the study are consistent with previous psychoanalytic research suggesting that psychopaths live in a primitive (borderline) world of object relations (Gacono and Meloy, 1991). The psychopath's presocialised world appeared to be dominated by more primitive defence mechanisms, such as massive denial, devaluation, omnipotent control, splitting and projective identification. As aforementioned, these psychological defences are corollaries of both a schizoid-paranoid position (Klein, 1946) and borderline personality

organisation (Kernberg, 1984). To maintain his narcissistic pseudo-autonomy, the psychopath must be aggressive towards other people in highly destructive ways, leaving a trail of hurt people behind him.

6.3.4 The revenge of the beaten child

The primary unconscious aim of the sadistic aggression in psychopathy appears to be, we believe, to maintain the archetypal pathological formation of the grandiose self-structure; a state of omnipotent pseudo-autonomy. As a sadistic psychopath commented: *"I was recognised as one of the most violent individuals within the prison system. Someone could happen to walk on me, and I would be on top of him in a second."* Another patient said: *"They underestimate me… I never lost a fight. I am quick and everything."* When asked about the meaning of his aggression, a sadistic psychopath said *"It's a bit of a show… to show to other people 'Just don't mess with me."* It appears that the psychopath's sadistic aggression helps him to maintain his narcissistic equilibrium. His omnipotence, as Steiner (1993) would have put it is a 'psychic retreat' that compensates him for the deprivation and derogation he suffered as a child.

As mentioned earlier, the other significant function of a sadistic psychopath's aggression is to keep the internalised 'beaten child' safe. This was also very present in the sadistic psychopath's narratives: *"I try to avoid violence at all cost. If I can walk away, I will walk away, but I am not saying that I can't handle myself. I can handle myself. I got involved in fights in prison, but this is the last resort, the very last resort. But I wouldn't tolerate someone bullying me… That's a bully. It's different."* A very violent sadistic psychopath also said: *"I think I get mostly aggression when I feel let down for no reason… We become within ourselves that we feel hurt again… hurt is coming. I have the saboteur in me… I don't let the person get too close to me, I am starting to feel uncomfortable."*

I named this type of violence the 'acting out of the beaten child' or the 'internal saboteur' as a psychopathic patient best described it. It appears to me that the sadistic psychopath acts out in order to protect this internalised and deeply traumatised child. From this point of view, sadistic aggression within the construct of psychopathy can be conceptualised as the revenge of the beaten child; a child who will not tolerate any more abusive behaviour. An important difference between sadistic and non-sadistic psychopathy was that sadistic violence was not primarily directed at strangers (e.g. at people that sadistic psychopaths did not have any contact with, or at people who simply had an argument with him), but at people with whom the sadistic psychopath had a more intimate relationship (e.g. staff members, carers, fellow inmates etc). This finding is in contrast with previous theoretical speculations which suggested that psychopathic crimes are motiveless (Juni, 2009).

6.3.5 Repetition compulsion in psychopathic and sadistic patients

Contrary to this assumption, thematic analysis appears to show that psychopathic crimes can be considered as highly structured rituals of violent and gruesome re-enactments which are related to severe past traumatic events. Although the victim selection in sadistic psychopathy appears to be ostensibly random, a careful examination of the victim-perpetrators' dynamics revealed that most of the victims had a symbolic significance to the perpetrator. The victim chosen, in our view, is reminiscent of significant others in the psychopath's primary trauma and it can be understood as a case of transference, projective identification and repetition compulsion. This can be observed in patients' comments under the theme 'The psychopathic symbol formation' in Chapter 5.

To further understand sadistic aggression within the construct of psychopathy, we need to examine the psychopath's complementary and concordant identifications with his internal objects. Both identifications are carried out by way of transference and projective

identification. Concordant identifications are formed when an individual identifies with a part of another person's personality (Meloy, 2005). Such identifications are conscious and ego-syntonic. By the same token, complementary identifications are formed when a person is identified with someone else's internal objects. Complementary identifications are unconscious, ego-dystonic and 'may recapitulate a relationship to an early actual object that has now been internalized' (Meloy, 2005, p. 91).

Complementary and concordant identifications in sadistic psychopathy can be understood as a special case of transference. The concept of transference, which is historically rooted in psychoanalytic literature, involves repetition and replaying of old agendas in response to current situations. Previous studies have empirically confirmed the clinically observed phenomenon of transference. For instance, children who have suffered domestic violence and abuse appear to have a tendency to marry abusive spouses in their adulthood, whereas children of alcoholics have the tendency to repeatedly marry alcoholics (Griffing et al., 2005; Olmsted, Crowell & Waters, 2003).

The transference phenomenon in sadistic psychopathy is more malignant and it triggers the repetition compulsion. The psychopathic mode of repetition compulsion involves ritualised aggressive re-enactments in the here and now. Qualitative analysis showed that these re-enactments appear to be repetitive replays of old, unresolved trauma. This was more noticeable in sexually sadistic psychopaths (see Chapter 5). Dynamically, this malignant mode of repetition-compulsion has an ameliorative function as it aims to alleviate internal intolerable states of pain.

Despite the differences in the function of aggression between sadistic and non-sadistic psychopathic patients, their mode of violence was mainly reactive/affective. This is in contrast to previous research suggesting that psychopaths engage in more predatory modes of violence. It must be noted, however, that the vast majority of psychopathic patients in the

current sample scored lower than 30 on the PCL-R (only 2 patients scored above 30), so they were not diagnosed with severe psychopathy. It is possible that the more severe the psychopathy is, the more instrumental the psychopathic aggression will be.

Thematic analysis further indicated that relational violence appears to be another type of sadistic violence within the construct of psychopathy, at least in the present sample. It was also present in the group of non-sadistic psychopaths, although to a much lesser extent. Relational violence (RV) is defined as physical, sexual and psychological aggression that occurs within a relationship, mainly by a current, or former partner (Oka et al., 2014). Four types of relational violence have been identified, namely, situational couple violence; mutual violent control; violent resistance; and intimate terrorism (Johnson, 2006).

Most central to this study appear to be the intimate terrorism type of relational aggression. Intimate terrorism is defined as the one-sided use of violence that aims to control and dominate the partner (Johnson, 2008). This theme was reflected in the narratives of several sadistic psychopaths. As one patient conveyed to me: *"I got down against my ex-wife for domestic abuse… What I didn't tell you was that I was also convicted for a rape. It was one of the times that I met up by accident with a lady that came over to me. And there was a massive explosion at the moment. By 2 o'clock in the morning, I drunk 5 bottles of Jack Daniels. The offence occurred. Genuinely, I got no memory of the offence". The presence of relational violence may be a peculiar characteristic of this specific group of patients, who considered as responsive to treatment and therefore got admitted to secure psychiatric services, whereas other patients with psychopathic and sadistic traits who aggress against strangers may not be seen.*

The sub-theme 'The acting out of the beaten child' was labelled as such when it became apparent that the function of aggression in both sadistic and non-sadistic psychopaths was mostly a way to protect their vulnerable selves and to defend against the pain and

humiliation they had suffered in their childhood. In those cases, aggression was a 'retreat' to a safe place; a place where internal and emotional homeostasis was temporarily maintained. Notably, psychopathic participants commented that violence helped them to calm down.

Aggression in sadistic psychopaths had, as expected, more sadistic elements. The sadistic nature of their aggression, however, was not pleasure-seeking, deriving from the hurt and humiliation of another human being, but a desperate need to control the impact that the words and acts of the other people had on them. The ultimate intent to hurt or humiliate another person is the feeling of discomfort and pain that the victim experiences. Pleasure is only secondary to sadistic psychopath; the victim's suffering enhances his feeling of delusional triumph and grandiosity. A victim's submission to his omnipotent control, allows the psychopath to feel that he is control.

By exploring the sadistic psychopath's relationship with his victims, it became more apparent that sadistic violence in psychopathy is object relational in nature. First, the psychopath's sadistic violence was mostly directed at people with whom he had an intimate relationship. Notably, all sadistic psychopaths' victims were known to them. They were either family members or close friends. Second, thematic analysis revealed that on most occasions, the victim was important to the perpetrator, as they had a symbolic representation for them.

6.3.6 Identification with the aggressor

A closer look at a psychopath's early identifications and object relations may offer a plausible explanation of his sadistic aggression. As presented at the beginning of this thesis, the early affective development is based on the fixation of the very early affectively charged object relations, which forms the individual's affective memory (Kernberg, 1991). Sadistic psychopaths conveyed that they had experiences of savage aggression from the father, or the mother or sometimes from both parents and experienced various types of abuse and neglect in

their early childhood. These patients also commented on the absence of any good object relation and the subsequent feelings of helplessness they experienced in their childhood.

To survive in such a hostile world, the psychopath had to form a concordant identification with the cruel, powerful and sadistic paternal object. The only identification a psychopath can form is therefore the identification with the aggressor (A. Freud, 1936; Ferenczi, 1933) or the identification with the stranger self-object (Grotstein, 1982) or the predatory part-object (Meloy, 2001). To survive the abuse, the sadistic psychopath becomes what he is most afraid of: he becomes a father-predator.

From a psychodynamic and attachment viewpoint, the internalisation of such a sadistic parental figure leads to the development of an overwhelming atavistic fear of predation. Savage aggression, traumatic bonding and abuse from the primary caregivers are the psychodynamic roots of the identification with the aggressor (see Chapter 5). Psychopaths' persecutory introjects were transformed into predatory identifications, which possibly have their roots in the very early experiences they had with abusive and neglectful parents. The sadistic psychopath's early unconscious identification with the aggressor helped him to cope with the anticipation of aggression from the paternal object during childhood. The child inevitably internalises and identifies himself with the sadistic caregiver 'as a predator for whom he will eventually no longer be a prey but will instead prey on others' (Meloy, 2001, p. 13).

The pain of having to depend upon a sadistic, but desperately needed, paternal object is transformed into and expressed as rage which is projected towards others. Rage is the basic affect state that activates aggression in the transference (Kernberg, 1991). Developmentally, the primordial function of rage in sadistic psychopathy is to eliminate pain. From an object relational perspective, rage signifies the activation of all-bad and persecutory internal object

representations and aims to restore the psychopath's narcissistic equilibrium, namely the grandiose self-structure, by destroying the source of pain and frustration.

The psychological defense of splitting and projective identification predominate in the sadistic psychopath's internal world. A psychopath's persecutory internal world and sadistic object relations are not experienced as part of the self, but these objects are projected to others who are subsequently experienced as threatening. Patients' narratives reflect these gruesome re-enactments which are related to severe past traumatic events. The psychopath is identified with the predatory paternal object and exercises omnipotent control over his victims through sadistic violence.

The 'acting out of the beaten child' was also present within the group of non-sadistic psychopaths, however to a lesser extent. Indeed, there appeared to be considerable differences in the intensity and function of aggression, which were less frequent, less sadistic and less intense in non-psychopaths. It was notable that the victims of non-sadistic psychopaths were mostly strangers and the crimes were not specifically motivated. It seems that violence in non-sadistic psychopathy is less object-related compared to violence in sadistic psychopathy. Like the function of aggression in sadistic psychopathy, violent acting out in non-sadistic psychopathy is aimed at alleviating feelings of rage; to achieve internal homeostasis and to protect the psychological self.

6.3.7 The Murder of Clytemnestra

Envy and hatred are at the heart of a sadistic psychopath's internal world. These complex aggressive affects were very present prior to, as well as during, the crime. The primary aim of a sadistic psychopath's hatred was to destroy the object. The destruction of the object not only occurs in external reality, but also refers to the representation of the object in his unconscious phantasy. At base, the object is needed and desired and its destruction is equally desired. This was illustrated in the case of a non-sadistic psychopath who attacked a

pregnant doctor because, according to him, she declined to give him his medication (see Chapter 5). The doctor had a miscarriage and the patient claimed that he had no memory of the event. The patient said that he was extremely angry with her and he just wanted to hurt her. This is an extreme form of hatred that demands the physical elimination of the object through its radical devaluation.

Paradoxically, a more severe degree of hatred was expressed by non-sadistic psychopaths. It appears that the primary aim of the non-sadistic psychopath is the total destruction of the object, whereas a less severe degree of hatred is expressed in sadistic psychopathy, where the ultimate aim is the suffering of the object. Those differences in aggressive affects and function of aggression between sadistic and non-sadistic psychopaths support the hypothesis of the existence of two types of hostile psychopathy, namely the aggression-driven and the sadistic psychopathy (Juni, 2010).

Envy, a more primitive form of hatred, intimately linked with savage aggression, was also notable in psychopathic and sadistic crimes. Envy is the destructive attack on the sources of life, on the good object, and is one of the primary constitutional feelings of the psychopath. It is the feeling that goodness lies outside the self. The psychopath, as discussed earlier, has not developmentally reached the depressive position and object constancy has not been attained as he is fixated in a paranoid-schizoid position. As a result, the psychopath cannot mitigate feelings of envy by love and gratitude, but he wards off envy through the destruction of goodness in others. Behind the psychopath's envy is the desperate need to spoil anything good that might come from a human relationship.

Envy in psychopathy, as reflected in patients' narratives, comes from the unconscious identification with the (un)dead mother, which is psychopath's most hated and at the same time most needed object. The psychopath is enacting an object relation dynamic between the aggressor and the victim. The only alternative to being the victim or, in other words, the

beaten child is to identify with the father-predator. Sadistic aggression appears to be the only solution and form of survival. In this study, psychopaths' envious attacks on the object ranged from grievous bodily harm to severe sexual sadistic behaviours, murder and torture of the victim. Inspired by the Greek myth, I symbolically named the psychopath's envious attacks on the good object 'The murder of Clytemnestra' and this has its roots in the early identification with the (un)dead mother.

Clytemnestra's murder is illustrated in the second part of Aeschylus' trilogy *The Oresteia*. In the first part of *The Oresteia,* Clytemnestra and her lover Aegisthus plot to murder Clytemnestra's husband, Agamemnon, who is coming back to Greece after the end of the war in Troy. Clytemnestra is seeking revenge from Agamemnon for the sacrifice of her daughter Iphigenia and for Agamemnon's affair with another woman, whom he brought back to Greece as his mistress. On Agamemnon's arrival, Clytemnestra cons and deceives him by treating him as a real hero and the same day she kills him with the help of Aegisthus.

In the second part of the myth, Orestes, the son of Agamemnon, who grew up in exile following the assassination of his father, returned to his homeland to take revenge for his father's death. Although he desperately wanted to avenge his father, the idea of killing his mother horrified him. He then turned to his loyal friend Pylades to seek advice and the following dialogue takes place:

ORESTES: Pylades, what shall I do? To kill a mother is terrible. Shall I show mercy?
PYLADES: Where then are Apollo's words? His Pythian oracles? What becomes of men's sworn words? Make all men living your enemies, but not the gods. (Aeschylus, 1986, p.136)

In the above-mentioned dialogue, Pylades tries to persuade Orestes to obey the paternal God who orders him to kill his mother. Orestes is caught in an internal conflict

between two internal objects and he needs to decide with whom he will identify and whom he will murder. Before he murders Clytemnestra, the following dialogue takes place:

CLYMEMNESTRA: Beware the hounding Furies of a mother's curse.
ORESTES: How shall I escape my father's curse if I relent? (Aeschylus, 1986, p.137)

Orestes eventually decides to follow the paternal command and murder his mother. From a psychoanalytic point of view, I believe, the myth depicts the sadistic psychopath's internal world as illustrated in their narratives. It represents a symbolic matricide that signifies an attempt to destroy the goodness in others. Like Orestes, the sadistic psychopath follows the paternal command and he symbolically kills his mother. Mother's murder leads to identification with the father-aggressor; however, this has devastating consequences in the psychopath's psyche which is filled with devastating pain. The symbolic assassination of the psychopath's mother also represents a violent separation from her. Here the murder is necessary, as the psychopath does not have the capacity to tolerate ambivalence and thus, he has to kill off his feelings of dependency. No human being can kill off the very vulnerable part of himself without killing the good part. By murdering his mother, the psychopath robs himself of all human qualities. He castrates himself of all affectionate feelings. The tragedy is that this murder can never be successful: the mother will always live (un)dead within the psychopath's psyche.

Considering Melanie Klein's theory (1946), we can argue that the identification with the mother is the first significant developmental cornerstone in a child's life. She postulated that this first identification is accompanied by intense feelings of envy, as the mother has everything the infant wants to possess (Klein, 1957). For Klein (1957) the identification with

the mother occurs in the anal phase and is linked with sadism, as the infant wants to possess the mother's body which is the source of all goodness and gratification.

Sadistic psychopaths' narratives reflect that their maternal object was primarily abusive and neglecting, whereas in non-sexually sadistic psychopaths, it was cold, distant and indifferent. The basic affective state in sexually sadistic psychopaths towards their mother was intense rage and hatred, whereas non-sexually sadistic patients appeared to be angry and frustrated. Indeed, both sadistic and non-sadistic psychopaths experienced cruel aggression from their maternal object and as a result, they appeared convinced of the impotence of any positive, all-good object relationship. The powerful sadistic and indifferent mother, however, was needed for the psychopath's survival and the pain of having to depend on such an aggressive but desperately needed mother is transformed into hatred and envy.

The 'Murder of Clytemnestra', therefore, refers to the dis-identification with and the symbolic murder of the psychopath's mother that leads to a sadistic pseudo-identification with the father-predator. I believe that the murder of the mother can be interpreted as the sudden and violent dissolution of the Oedipus complex, which inevitably involves feelings of atavistic fear and persecution. It is my hypothesis that the murder of the mother in psychopathy not only signifies a destructive attack on the perceived source of goodness but it is also an unconscious attack on the helpless, fragile and vulnerable part of the self who desperately needs what Seymour Halleck (1966, as cited in Meloy, 2001) a long time ago proposed as a 'painless freedom object relationships' (p.160).

The murder of the mother and the concordant identification with the father-aggressor protects the psychopath's grandiose self-structure. Intrapsychically, psychopaths' persecutory introjects of the (un)dead mother and the predator father are projected onto the victim and affective tones of envy and hatred emerge as the psychopath wishes to exercise omnipotent control over the victim. At the interpersonal level, the victim is experienced as threatening

and he or she is identified with the psychopath's persecutory introjects. In sadistic psychopathy and in particular, in cases of severe sexual sadism, thematic analysis has shown that the sadistic psychopath has to maintain omnipotent control at all costs; mainly by degrading and devaluating the victim who suffers what the psychopath had suffered in his early childhood. This was reflected in the accounts of a sexually sadistic psychopath who sadistically raped his ex-partner seeking revenge because she wanted to leave him.

6.4 The contribution of trauma to the relationship between psychopathy and sexual sadism

6.4.1. Measurement of the trauma

In this study, aversive childhood experiences were measured by the Traumatic Experience Checklist (TEC). As expected from previous studies in the same population, TEC demonstrated an excellent internal reliability and a high internal consistency. The first three TEC sub-scales (Emotional Neglect, Emotional Abuse and Bodily Threat) displayed relatively good internal reliability, whereas the last two (Sexual Abuse and Sexual Harassment) displayed poor internal reliability. TEC was chosen to measure trauma for two main reasons: first, because it is a psychometric tool which was previously used in forensic research and specifically in psychopathic patients; and secondly, because it is a comprehensive measure of traumatic events that includes a cumulative score as well as scores for specific areas of trauma, namely emotional neglect, emotional abuse, physical abuse, sexual harassment, sexual abuse, and bodily threat from a person. Several participants found TEC 'too emotionally intense', whereas others said it took a relatively long time to complete.

6.4.2 Summary of the main findings

6.4.3 Psychopathy, sexual sadism and trauma

So far, I have argued that psychopathy and sadism are interrelated constructs and that the presence of sadism predicted psychopathy at least in the current sample of 59 violent and sexually violent forensic mental health patients. Indeed, the findings of both the quantitative and qualitative part of this study appear to support the psychoanalytic hypothesis that sadism is a severe manifestation of psychopathy and it constitutes a distinct type of disorder, namely sadistic psychopathy. I shall now move to the discussion about the findings with regard to the contribution of early traumatic experiences in the psychogenesis of sexual sadism and psychopathy.

As was mentioned in Chapter 2, research has shown that there exists a necessary, but on its own insufficient biological substrate to explain the development of psychopathy. The aim of this thesis, however, was to go beyond the nature vs nurture dichotomy and thus, to examine the psychogenic and environmental factors that contribute to the development of the disorder and prompt antisocial and violent behaviours. It aims to show how these early developmental influences and traumatising events shape the psychopathic and sadistic personality and build up psychopaths' and sadists' internal worlds.

Apropos of the relationship between sexual sadism, psychopathy and trauma, this study aimed to test the following four hypotheses: i) exposure to trauma during early childhood is associated with the development of more severe sadistic and psychopathic traits; ii) adverse experiences will be associated with sexual sadism, iii) adverse experiences will be associated with psychopathy; and iv) sadistic psychopaths will present higher levels of early childhood trauma compared to non-sadistic psychopaths. All of the aforementioned

hypotheses were upheld by the study apart from Hypothesis 4, as no significant differences in the levels of trauma between sadistic, and non-sadistic psychopaths were found.

As expected, the empirical findings appear to confirm what has been theoretically known and clinically observed, that psychopathy and sexual sadism were both positively, as well as significantly, correlated with trauma. It is unsurprising that sexual sadism was significantly correlated with TEC scales which reflect sexually traumatic experiences (Sexual Abuse and Sexual Harassment Scale). Although a significant covariation between trauma and psychopathy was found, no significant correlations were reported between TEC scales and psychopathy. The only significant correlation found was between PCL-R total score and TEC emotional abuse scale. This finding appears to show that there is an association between emotional abuse and psychopathy, which is also confirmed by the qualitative results. When multiple regression analyses were run between areas of trauma and psychopathy, no TEC scale predicted the disorder.

Those findings confirm two primary hypotheses of the study, namely, i) adverse experiences will be associated with sexual sadism, and ii) adverse experiences will be associated with psychopathy. Unfortunately, the absence of PCL-R facet scores did not facilitate the exploration of the relationship between trauma and Interpersonal/Affective, as well as Antisocial/Lifestyle facets. Previous studies, however, have shown that various types of abuse were differentially associated with the PCL-R facet scores (Krstic et al., 2016).

An unexpected finding was the absence of any association between trait sadism, as measured with the ASP, and trauma. Sadistic traits did not display any association with TEC and its scales. This finding may indicate that trauma is probably associated with more severe forms of sadism, and particularly with severe sexual sadism, but not with sadistic traits. It can

be argued that more severe forms of trauma are related to more severe and sadistic forms of aggression.

As hypothesised, psychopathic participants scored significantly higher on TEC compared to the non-psychopathic ones. Surprisingly, there were no significant differences in traumatic experiences between those psychopaths who had more sadistic traits and the ones who had less sadistic traits. Regression analysis has further shown that trauma and areas of trauma failed to predict trait sadism. It appears that sadistic traits do not account for more severe forms of trauma. Sadistic psychopaths, however, reported higher scores on the TEC Sexual Abuse scale. This was also confirmed by the semi-structured interviews. Thematic analyses revealed that both sadistic and non-sadistic psychopaths experienced one or a few, and some of them experienced all the following early aversive childhood experiences: neglect; parental humiliation; psychological abuse; Helplessness; and foster home placements. There were only subtle differences in the narratives of sadistic and non-sadistic psychopaths with regard to the severity of trauma.

By the same token, and in accordance with the hypotheses of the study, sexual sadists reported significantly higher scores on TEC compared to the non-sexual sadists. Furthermore, sexual sadists presented higher mean scores on the TEC Sexual Harassment and Sexual Abuse scale. This finding appears to indicate that a link exists between sexual abuse and the development of sexual sadism. Furthermore, sexually violent participants also presented higher scores on TEC compared to violent ones. It seems that sexual violence plays an important role in the development of psychopathy and sexual sadism and is also associated with more traumatic experiences.

This finding is also reflected in the qualitative part of the study. Psychopathic patients who presented severe sexually sadistic behaviours experienced more severe forms of trauma compared to the non-sexually sadistic ones. They mostly reported domestic abuse, domestic

violence, drug use and on several occasions, sexual abuse. Neglect and absence of warmth and intimacy were very present as well. Parental humiliation was also very relevant to the sexually sadistic psychopath. Indeed, all sexually sadistic psychopaths suffered humiliation from one or both parents. Some of the comments were related to their sexuality (e.g. inappropriate sexual comments); lack of masculinity and manliness; or abusive language.

In contrast to what was expected with regard to the relationship between trauma and sexual sadism, regression analysis showed that TEC total score failed to predict sexual sadism. When TEC scales were added to the regression model, however, it was found that only sexual abuse predicted sexual sadism. Indeed, regression analysis confirmed that sexual abuse is a strong predictor of sexual sadism, explaining almost 40% of the variance in data.

It is hypothesised that this premature introduction to sexual life led the child to develop a preoccupation with sex and to become hypersexual. Exposure to an erotically seductive environment for a boy who, for instance, was born with a genetic risk of violence, can steer his course toward sexually sadistic crimes rather than violent crimes. Being seduced by the mother or being sodomised by the father may also be related to the development of poor impulse control, a key trait in psychopathy and sexual sadism. It is possible, therefore, that sexual over-stimulation early in childhood is linked with the development of poor impulse control later on in adulthood.

Given his poor impulse control and absence of sublimation channels, the sexual sadist is doomed to engage in a repetition of this maladaptive pattern. Acting out is a significant part of the psychopathic and sadistic repertoire. From a psychoanalytic viewpoint, however, acting out is considered as an unconscious psychological defence against threatening feelings and it occurs when the psychopath and the sadist experience others as hostile and potentially dangerous.

As was hypothesised, regression analysis showed that trauma was a significant predictor of psychopathy, explaining approximately 92% of the variance in the data. This finding indicates that participants with higher psychopathy scores suffered more severe trauma in their early childhood. This finding is also in accordance with previous studies, which have underscored the contribution of trauma in predicting psychopathy (Krstic et al., 2016; Farrington, 2006, 2002; Graham, Kimonis, Wasserman, & Kline, 2012; Schimmenti et al., 2014).That confirms the primary hypothesis of the study which suggested that exposure to trauma during early childhood is associated with the development of more severe psychopathic traits.

6.4.4 Traumatic experiences in early childhood between sadistic and non-sadistic psychopaths

Although the findings from the quantitative part of the study showed no considerable differences in trauma between sadistic and non-sadistic psychopaths, qualitative interviews offered an exploration of the impact of those traumatic experiences through the subjective experience of each participant. Arguably, the theme of 'traumatic experiences in childhood' was the biggest overarching theme to emerge from the data. Participants' narratives revealed that both sadistic and non-sadistic psychopaths experienced some or all of the following aversive childhood experiences: neglect; parental humiliation; psychological abuse; helplessness; and foster home placements. The 'house of psychopathy and sexual sadism' appears to be built on those aforementioned areas of trauma. In accordance with the quantitative findings of the study, no considerable differences in the level of trauma were found in the narratives of sadistic and non-sadistic psychopaths.

Neglect

Neglect was a sub-theme of considerable significance in sadistic, as well as non-sadistic psychopaths. The level and impact of parental neglect was not much different within

the two groups of participants. Interviews showed that parental neglect from the mother was more damaging during the first years of life than neglect from the father. Some participants experienced neglect from their mother, whereas others where neglected by their fathers. On several occasions, however, patients experienced neglect from both parents. Both sadistic and non-sadistic psychopaths reported feelings of helplessness due to the absence of their maternal object.

Neglect from the father played an important role but mainly in participants' preteen and teenage years. It is striking that the participants specifically drew attention to emotional neglect. A few of them said that there was no financial neglect and they emphasised the antithesis between having a parent who 'pays the bills' or 'puts a roof over their head' and at the same time a parent who 'did not bother as such' and 'hadn't really looked after them'.

To grow up deprived of the mother's love robs the child of all his human qualities and leaves him utterly helpless. As early as 1944, John Bowlby came to the same conclusion, suggesting that parental neglect and prolonged separation of a child from his primary caregiver during his early years can lead to the development of 'affectionless psychopathy'. He further argued that parental neglect stimulates the inhibition of love by rage and hatred (Bowlby, 1944). A decade later, one of the world's foremost psychoanalysts, Donald Winnicott (1956), postulated that true deprivation and loss of the good object in childhood are the roots of antisocial behaviour.

No different conclusions were drawn by the qualitative results of this study. Parentally deprived participants grew up handicapped in similar ways. Given the absence of any good object to rely on, they filled up with envy and hatred for their parents, as well as for all other people. Their violent and sadistic behaviour later in their adulthood was their antidote to the abandonment and neglect by their significant others.

Parental humiliation and cruelty

More than half of the participants had experienced parental humiliation, which mostly occurred during their childhood. There appeared to be certain types of humiliation that were difficult for the participants to tolerate and, thus, created vicious cycles that undermined their self-esteem. Participants reported hurtful remarks related to their sexuality (e.g. inappropriate sexual comments); remarks on lack of masculinity and manliness; or abusive language in general. Humiliation usually co-occurred with other aversive experiences, such as neglect or abuse. Considering that psychopathic patients were very reluctant to reveal feelings of vulnerability, shame and humiliation, the identification of the sub-theme was based on implicit statements that reflect shame and humiliation. It is unsurprising, however, that almost no psychopathic patient explicitly conveyed feelings of humiliation.

When humiliation came from the mother, it was more painful and devastating than when coming from the father. Although most of the patients were actually more severely abused by their father than their mother, they were able to justify and/or show some (pseudo) forgiveness to him. This was probably due to a very early identification with the father-aggressor. When feelings of humiliation were triggered by the mother's neglect or abusive behaviour, the patients were full of rage and hatred, seeking revenge for what had happened to them. Although parental humiliation equally occurred in both sadistic and non-sadistic psychopaths, it was notable that non-sadistic psychopaths did not conceal their feelings of humiliation and they openly discussed them.

Apropos of parental cruelty, about two psychopaths out of three experienced physical, sexual and emotional abuse. Only three patients stated that they suffered no abuse in their childhood. Along with neglect and parental humiliation, parental cruelty had a considerable impact upon adult personality development in both sadistic and non-sadistic psychopaths. Nevertheless, sadistic psychopaths suffered more physical abuse, which on a few occasions

co-occurred with sexual, as well as emotional abuse, than the non-sadistic psychopaths. In both groups, however, the acts of cruelty were mostly committed by the father, leaving the participants utterly helpless in the face of his savage aggression.

Adoption and foster home placements

Although there is no direct link identified between violence and adoption, 7 out of 18 psychopaths were either adopted or grew up in foster homes. Interestingly, 5 out of 8 sadistic psychopaths were adopted or grew up in foster homes compared to only 2 non-sadistic psychopaths. Arguably, being adopted or growing up in a foster home is not necessarily considered a traumatic experience as many children are adopted by loving and caring parents. By the same token, it is very likely that these patients had experienced abuse and/or neglect at a very young age. As was mentioned in the previous chapter, in England and Wales adoption and foster care are interventions targeted at children who had experienced abuse and/or neglect. This may also indicate that the attachments of the patients who were adopted or put in foster care had been disrupted at a very early age.It is further hypothesised that the participants experienced adoption or being put into care as rejection or abandonment by the primary care givers. It is possible that participants who were adopted developed envy and hatred towards their primary care giver, which were later projected into other people.

A few studies appear to show that there is some connection between foster care and adult criminality (Lindquist & Santavirta, 2014; Yang et al., 2017; 2020). Indeed, foster care placements are associated with maltreatment and abuse, which have been considered risk factors for violence and offending. Notwithstanding that there are probably peripheral risk factors associating foster care and adoption with a higher rate of chronic offending trajectory, it is unclear whether adoption and foster care constitute their own type of adverse experience that contribute to violent behaviour and offending, or it is the very early experiences of abuse

and neglect that lead to disruptions of the attachment with the primary care givers, which in turn are risk factors for the development of offending, psychopathy and sadism.

Helplessness

The absence of any compensating maternal influences from any other sources made feelings of helplessness more intense and created a real Hell on Earth. That was the case for most of the sadistic and non-sadistic psychopaths, although not to the same extent. During the interviews, the participants were asked whether they could rely on anybody to make them feel better and/or safe. Not surprisingly, most of the patients felt helpless towards their 'parents from hell'. Indeed, no one was around to help and support them when needed.

Sadistic psychopaths seemed to experience more intense feelings of helplessness than non-sadistic ones. They clearly conveyed that there was no one available to help and support them. Because no person was available for them to rely on, they felt they had to 'manage alone'. Lack of support earlier in a child's life affects his ability to develop normal dependency on people. Nevertheless, psychopaths felt isolated. On several occasions, they felt rejected when they tried to reach out for help from significant others. As a sexually sadistic psychopath conveyed to me: *"When my mum was around, I was like: 'Mum, I am a bit concerned blah blah blah…' child language you know… But she was like 'Don't bother me, I got other things to worry'.* We will elaborate more on the lack of capacity to depend in the attachment section.

Any form of neglect, or abuse, however, occurs within the context of an interpersonal relationship and when it comes from the most significant people in someone's life, namely the parents, it leads to the development of severe trauma that affects personality development. To understand how the psychopath relates to others, we need to carefully examine his early relationships with his primary care givers. The early relationship with the primary caregivers was the first theme identified through the participants' narratives. Three subsequent themes

were identified under this main theme: the (un)dead mother, the 'as if' mother, and the 'predator parental object'. All these sub-themes were very present in both sadistic and non-sadistic psychopaths' narratives.

6.4.5 Early relationships with primary caregivers

The (un)dead mother and the 'as if' mother were the two types of psychopaths' maternal object as identified through their narratives. As briefly discussed in the results section, the term (un)dead derives from a combination of André Green's (1986) 'dead mother complex', which portrays an emotionally cold, distant and withdrawn mother, as well as Christina Wieland's (2002) concept of the 'Undead Mother' that refers to the symbolic murder of someone's feminine side that leads to dis-identification and violent separation from the goodness of the internal mother.

Psychoanalysts have long suggested that the very first relationship with the mother is crucial in the development of a healthy self-concept and stable identity. Melanie Klein (1946) theorised that every infant struggles with two different types of anxiety: the fear of annihilation (that is paranoid anxiety) and the fear of abandonment (depressive anxiety). This finding led her to suggest that the human psyche is oscillating between two universally organised modes of experience: the paranoid-schizoid and the depressive position (Klein, 1946). Further, Klein's positions reflect both an organisation of experience, as well as a mode of relation to the world.

Klein also postulated that the infant's unintegrated ego cannot tolerate the early psychotic anxieties triggered by the operation of the death drive within the self. In order to cope with the fear of annihilation, the infant splits the mother into good (gratifying mother) and bad (frustrating mother). In Kleinian terms, this refers to a split between good and bad breast (Klein, 1946). Although Klein suggested that object relations exists from the beginning of life, she posited that the infants early ego cannot integrate antithetical experiences as the

infant cannot realise that the mother who satisfies him is the same mother who frustrates him (Klein, 1946). This is a severance between love and hate. The human psyche is, therefore, oscillating between feelings of love and hate.

According to the object relations theory, the cornerstone of personality development is the level of internalised object relations an individual has reached (Kernberg, 1980). If the early positive and gratifying experiences predominate over the frustrated and painful states then the individual does not reach, as discussed in detail in Chapter two, the developmental stage of object constancy or its corollary, the depressive position, where positive and negative affective states are integrated within the personality. The failure to integrate positive and negative aspects of the self, as well as of the significant other leads to borderline personality organisation, which is characterised by identity diffusion (Kernberg, 1975). It is further argued that early aversive and painful childhood experiences lead to affectionless psychopathy (Bowlby, 1944); antisocial tendency (Winnicott, 1956) or primary psychopathy (Meloy, 2005).

The (un)dead mother

I shall now attempt to explore how, in my view, the psychopath's early relationships with his primary caregivers shape his internal world. The psychopath's internal world is characterised by deadness. I argue that his dead internal world is the result of the internalisation and concordant identification with the (un)dead mother. Indeed, the 'deadness' of the maternal object is presented in a very lively way in the patients' narratives. Although there were no significant differences in the quality of psychopaths' relationships with their maternal objects between those who had more and those who had fewer sadistic traits, sexually sadistic psychopaths reported more traumatic experiences with their mothers.

The mother of the sexually sadistic psychopath was physically and emotionally abusive, as well as being a neglecting mother. By the same token, the mother of the non-

sexually sadistic psychopath appeared to be cold, distant and indifferent, but to a lesser extent, physically abusive. The basic emotional state of sexually sadistic psychopaths towards their mother was intense rage and hatred, whereas non-sexually sadistic psychopaths appeared to oscillate between anger and frustration. Sexually sadistic psychopaths' rage was a response to humiliation from their mothers, rather than their fathers. As a sexually sadistic patient revealed to me: *"She is not my mother. Don't call her like that. I call her B. She is not my mother; she is not my mum. She never will be… She was supposed to be there to protect, love… but never did …She lost all the interest in me completely… even anger. She wasn't interested. Nothing. Never. She never made me feel loved and accepted."*

The 'as if' mother

The participants' narratives indicate that along with the '(un)dead mother', there is also the 'as if' mother, that reflects a fake and rather idealised picture of the patients' mother, who behaved 'as if' she was affectionate and caring. The 'as if' mother was present almost to the same extent in both sadistic and non-sadistic psychopaths. On several occasions, patients' narratives were found to be considerably different and sometimes totally different to what was written in their clinical assessment with regard to the relationship they had with their mother. The sub-theme 'as if' was not so much used to describe the actual quality of the maternal care or even the mother's behaviour towards the patient, but it mostly reflects the patient's need to restore a picture of a loving and affectionate mother that compensates for all the feelings of frustration and anger. This raises an important issue which can be expressed in the question: Why did psychopathic participants have the need to present a distorted and idealised picture of their relationship with their mother?

It is hypothesised that psychopathic patients presented the need to create, in their fantasy, a picture of a mother who loved them and cared for them. Idealisation is a primitive defence mechanism and most characteristic of borderline personality organisation. The

idealised picture of the maternal object appears to partly ameliorate the intense anger and rage towards her. The remake of the mother in a patient's fantasy aimed to help them to alleviate painful and devastating feelings of rejection, and also to protect the internalised picture of the mother by keeping things 'all good' and them safe from feelings of rage and hatred towards her. Interestingly, several psychopaths initially described 'all good', very positive relationships with their mother; however, on some occasions, that initial perfect image of their mother started to fade in the later stages of the interview as there were a lot of contradictory and sweeping statements with regard to the quality of maternal care. When questions about the relationship with their mother were asked, patients were either very laconic, or they tried to avoid the question by changing the subject or by talking about something unrelated.

The mother's deadness, however, appeared to lead to the formation of a sadistic pseudo-identification with the father, namely the identification with the aggressor or the identification with the 'predator self-object' in order to defend against the feelings of longing, as well as the murderous rage towards the emotionally unavailable (un)dead mother. In a few accounts, the rage and the hatred towards the (un)dead mother was more consciously expressed than in others.

The father-predator

As discussed earlier, the psychopath's father is a cruel, sadistic and abusive father. I chose to use the metaphor of the 'father-predator' influenced by a psychopathic participant's recurring dream. The participant was repeatedly having nightmares of being chased by predatory animals and he woke up in the middle of the night screaming his mother's name. This participant had been severely abused by his father in his early childhood and his dream was probably repetition of his primary trauma.

Overall, the participants' interview narratives clearly indicate that the father of the psychopath is a sadistic tyrant. On most occasions, he exercised savage aggression towards the participants in their early childhood. This type of aggression involved emotional, physical and on some occasions, sexual abuse. Like a carnivorous predator the psychopath's father was ready to attack his child-prey. He was experienced as a fundamentally distrustful antagonist that the psychopaths had to protect themselves from. Indeed, the paternal object seemed to function as a radically cruel figure in both sadistic and non-sadistic psychopaths. Psychopaths experienced intense rage and hatred towards their fathers. These affective states were clearly expressed in the participants' narratives.

6.4.6 The impact of early object relations on the psychopathic and sadistic personality

An important issue raised at this point concerns the impact of the psychopath's early relationships with his primary caregivers upon his adult personality development. Or, in other words, how do early object relations shape the psychopathic personality? Object relations and attachment theory suggests that the very first experiences and emotional interactions with the primary caregivers are internalised and thus create a framework that determines how the child will relate to the other later in his adulthood (Bowlby, 1969). This first internalised interaction between the child and the significant others form the child's internal working models (Bowlby, 1969), or his internal objects (Klein, 1946).

One theoretical assumption would be that the psychopath's internal world is organised upon the peak-affect states of hatred and envy. Their internalised object relationships are constituted of identifications of very persecuting objects. The psychopath has introjected a cold, indifferent and unempathetic mother and a sadistic, abusive and neglectful father. It seems to be a powerful link between the psychopath and the traumatising object(s) under the dominance of hatred and envy.

It is further hypothesised that intense attachment to the (un)dead mother facilitates the transformation of rage into envy. The psychopath's inordinate amount of envy is arguably rooted in his fixation with the traumatic relationship with the frustrating mother. The mother, who is the needed object, is experienced as all-bad and the envious attacks on her aim to restore the all-good one; however, that cannot be maintained as it leads to the destruction of the actual capacity to relate to the object. The predominance of aversive experiences and the psychopath's mother's failure to provide a good enough environment makes the depressive position developmentally unavailable.

It is further hypothesised that the failure of the maternal function, or in other words, the absence of the 'good enough' mother makes the introjection of the good object impossible. The (un)dead mother cannot contain the psychopath's early persecutory anxieties and fails to protect him against the cruel aggression of his father-predator. The absence of the good object and the subsequent failure to internalise it, may provide further aetiological explanation for his callous and unempathetic attitude.

From a dynamic point of view, we believe, the psychopath's callous, unempathetic and sadistic traits have their roots in the early identification not simply with the (un)dead mother, but with the relationship to her. As Kernberg (1991) rightly put it: 'Identification with a betraying object initiates the path to a revengeful destruction of all object relations' (p.28). The result of this identification is the transformation of the hatred of the mother as victimiser to a parallel identification with her as a source of destruction. The psychopath identifies not only with his suffering self but also with the sadistic object.

As aforementioned, the presence of the (un)dead mother along with the presence of a sadistic father-tyrant leads to a pseudo-identification with the father, namely the identification with the aggressor. This concordant identification with the father-predator helps the psychopath to defend against feelings of longing and murderous rage against the (un)dead

mother. The identification with the aggressor creates an equilibrium in relation to other people that enter the psychopath's world.

Psychopathic and sadistic aggression, in our view, represents a revengeful triumph over the needed object. The psychopath's violent, sadistic and gruesome re-enactments signify a symbolic revenge for the past suffering. During these insidious and threatening re-enactments, repetition-compulsion is triggered and usurps reality-testing during the episodic re-enactment. While sadistically attacking their victims, psychopaths experience themselves as being mistreated and thus they engage in role reversals; they are victims and perpetrators at the same time; the psychopath cannot escape from this dynamic as no victimiser can live without their victim. Their projected persecuted self is attached to the victim and the psychopath remains attached to his persecutors both internally, and sometimes, as happens in sadistic psychopathy, externally, through behaviour characterised by savage aggression.

6.5 Attachment abnormalities in psychopathy and sexual sadism

6.5.1 Measurement of attachment

As previously reviewed, two questionnaires were used to measure insecurities of attachment: The Relationship Scale Questionnaire (RSQ) and the Revised Adult Attachment Scale (RAAS). By evaluating two dimensions of attachment, namely anxiety and avoidance, the RSQ explores the following four attachment styles: secure, preoccupied, dismissing and fearful, whereas the RAAS examined the participants' feelings about romantic relationships organised into two broad attachment categories: attachment anxiety and attachment avoidance. The RSQ demonstrated very good internal reliability, whereas RAAS displayed poor internal reliability. It was notable that all the RSQ and RAAS subscales displayed poor internal reliability, probably due to the low number of questions.

6.5.2 Attachment, Psychopathy and Sadism

Apropos of the relationship between insecurity of attachment, sexual sadism and psychopathy, this study aimed to test two primary hypotheses, namely i) attachments in both sadistic and non-sadistic psychopaths will be more anxious, insecure and dismissing compared to non-psychopaths; and ii) attachment abnormalities will be associated with psychopathy and sexual sadism. Surprisingly and in contrast to our expectations, no association was found between attachment insecurity (RAAS, RSQ) and psychopathy. On the contrary, sadistic psychopaths were found to be more dismissing comparing to non-sadistic psychopaths and sexual sadists presented more severe insecurities of attachment compared to non-sexual sadists.

Bivariate analyses showed that no statistically significant correlation was found between psychopathy and any of the attachment abnormalities. Psychopathy was found to be negatively but not significantly correlated with secure and avoidance attachment styles. Similarly, no covariation was found between trait sadism and attachment insecurity. Sexual sadism, on the other hand, was found to be significantly but negatively correlated with attachment avoidance.

No significant differences were found in attachment mean scores between violent and sexually violent participants. When comparing attachment mean scores between psychopathic and non-psychopathic participants, it was found, as expected, that there was a negative association between secure attachment and psychopathy. Sexual sadists were significantly more avoidant and dismissing and considerably less secure than non-sexual sadists. Further, sadistic psychopaths were found to be more dismissing compared to non-sadistic psychopaths.

Surprisingly, no attachment insecurity predicted psychopathy. Although secure attachment was found to be negatively correlated with psychopathy, when we ran the regression analysis, no association was found between attachment insecurity and psychopathy. Previous research has vaguely shown that insecurities of attachment have been associated with antisocial and violent behaviour (Ribeiro da Silva, Rijo, & Salekin, 2015; Dutton, 2007); borderline personality disorder (Fonagy et al., 2000); and sexually coercive behaviour (Barbaro et al., 2018; Langton et al., 2017). This study, however, did not replicate those findings.

Given the aforementioned association between attachment abnormalities, violence and other severe personality disorders, an important issue is raised here, which can be expressed through the question: Why did attachment insecurities fail to predict psychopathy? Although providing a definite answer to this question is an ambitious task, we formed a few hypotheses which I will present to explain this finding.

Insecurities of attachment, although a disturbed attachment pattern, still reflect a mode of relationship with the other. There exist different types of attachment insecurity and all of them appear to reflect distinct object relational characteristics. Clinical work with psychopaths, however, suggest that most salient to psychopathic personality is the chronic emotional detachment from others, an attachment pathology that has been theoretically associated with emotional deprivation in early childhood. The psychopath is significantly more detached than the non-psychopathic individual and thus they cannot form affectional bonds with other people. Detachment, we believe, is not an insecurity of attachment but it reflects severe incapacity to form any relationship with other human beings.

To explain the absence of attachment in psychopathy, I shall now return to the 'murder of Clytemnestra', which represents the psychopath's symbolic murder of his mother. Looking at Mahler's (1979) theory of attachment, we posit that the 'murder of Clytemnestra'

occurred in the stage of separation-individuation and particularly during the rapprochement phase. In normal development, the separation, individuation phase signifies the differentiation of the self and the object representation. During the rapprochement phase, there is a growing uneasiness with regard to the separation of the mother, who is still idealised and feared. The child must give up his omnipotence and the dangerous situation being the loss of the love of the mother. The demarcation during this phase is between good and bad self-object representations.

It is further hypothesised that severe early relational trauma, as well as maternal abuse and deprivation disrupt the attachment processes. As almost all psychopathic patients were severely traumatised by their mother, we argue, that the psychopath's mother's abusive behaviour did not facilitate the process of separation. The psychopath had to devour, or, metaphorically speaking, to kill the mother to live with her symbiotically. By devouring or killing the mother, however, the psychopath cannot actually metabolise the maternal object. He has totally lost his primary attachment figure and the only way to survive is to form another primary attachment with a more abusive figure, namely the father-aggressor. So, the psychopath remains detached from the (m)other but at the same time, he forms a 'violent attachment' with his father.

This, however, raises another important issue, namely the relationship between trauma and attachment insecurity. The profound impact of childhood maltreatment on attachment behaviours has long been examined in the literature (e.g Cohen et al., 2017; Toof et al., 2020). Indeed, research has shown experiences of abuse and neglect are considered a sufficient, albeit not necessary condition leading to disruption of the attachment system (Cyr et al., 2010). Other studies have shown that specific types of abuse are associated attachment insecurities (e.g., Grady et al., 2020). More specifically, more contemporary research has shown that insecure attachments are over-represented in violent personality disordered

patients (McGauley, 2011). This association, however, was not observed in this study. Despite the significantly positive association between early childhood trauma and psychopathy, regression analysis showed that attachment insecurity as measured with the RAAS and RSQ failed to predict psychopathy.

By the same token, qualitative data analysis and patient's quotes indicates that insecurity of attachment appear to be present in the construct of psychopathy the current sample, albeit not predicted by regression analysis. For example, when a patient was asked to elaborate on his relationship with his primary care giver he responded with anger: *"She is not my mother. Don't call her like that. I call her B. She is not my mother; she is not my mum. She never will be…* You know…*that thing – so called – my mother, she is in her early nineties now and she is full of life, believe it or not. I haven't spoken to her for 38 years….She was supposed to be there to protect, love… but never did. 5 years… 4.5 years after I was born, she gave birth to her second child, it was a girl which she wanted… she lost all interest in me completely… even anger. She wasn't interested. Nothing. Never. She never made me feel loved and accepted".* This quote may indicate a dismissive state of mind and a denial of the patients emotional reality, an internal reality full of psychological pain and resentment.

An additional plausible explanation of why attachment insecurity failed to predict psychopathy may be related to the lack of efficacy of self-reports methods to assess unconscious states of mind. Although both the RSQ and RAAS have used before in studies with violent and sexually violent offenders, it is well – known that self-reports scales may not be valid, while other researchers (e.g Hare, 1993) suggest that they contraindicated to patients with strong psychopathic traits, due to the core features of psychopathy (e.g., deception, lying, manipulation).

From a psychoanalytic point of view, the insecure attachment state of mind is primarily an unconscious state of mind, which is manifested in behaviours that unconsciously

reenact previous attachments. The above-mentioned participant for example, who was severely abused by his mother in his early childhood, had described himself as "the king of the jungle" and "one of the most violent inmates in Britain". Here, the grandiosity could be interpreted as a defensive operation against an insecure attachment state of mind and the denial of vulnerability, psychological pain and mourning for a mother who " was never interested" and " never made [him] feel loved and accepted.

This unconscious reenactment of previous attachment relationships appeared to be present in the qualitative interviews and could be thought in the context of interpersonal violence, which was a mode of violence frequently observed in the participants of this study. This seems to be reflected in the case sexually sadistic psychopathic patient who was convicted for the rape of his ex-partner. This patient grew up in a violent and insecure environment with aggressive alcoholic parents, who used to lock him in a 'small place' because he was 'shouting, screaming and fighting with [his] brothers'. A couple of decades later this insecure attachment state of mind was violently reenacted, when he raped his ex-partner because she asked him to break up; "I said [to her] I had enough of you… you really took the piss out of me… I am gonna show you what I think about you…. "is this what you like'.

Violence, as Fonagy (2003) proposed, is unlearned through the formation of secure attachment associated with normal development and thus facilitates the impulse control, as well as the control of the innate aggression. When the family environment is dysfunctional, however, the child is not able to form secure attachment and their capacity to mentalise may be disrupted, therefore the process of socialisation and unlearning violence is disrupted. As the adult does not have the capacity to recognise emotional states both within himself and the other, the possibility of acting out those states is increased. As the same participant said to the researcher about the rape of his ex-partner: "*I just wanted her to feel how I felt. She really let*

me down and I felt really bad about it. I didn't want to end the relationship, I wanted her to think about it".

Those unconscious re-enactments of the insecurely attached mind were probably not captured by the self-reports methods. Previous studies (van IJzendoorn et al., 1997; Frodi et al., 2001; Levinson & Fonagy, 2004; McGauley, 2011); used the Adult Attachment Interview (George, Kaplan & Main, 1985), to assess the attachment representations in personality disordered offenders provided further empirical evidence to suggest that insecure attachment states of mind appear to be associated with violence and aggression in forensic population. A metanalytic review on the association between the AAI and self-report measures of attachments conducted by Roisman et al. (2007) has shown that the self-report attachment scales demonstrated 'trivial to small overlap between self-reported attachment style dimensions and AAI security (p. 693)

Although the AAI is considered as the 'gold standard' assessment of attachment and captures unconscious attachment representations (in contrast to self-reports who capture conscious experience of attachments), it is also associated with several difficulties. The AAI requires extensive training and is lengthy to administrate. Indeed, it would have been particularly difficult to administrate the AAI in addition to five questionnaires and one semi-structured interview in this study.

It seems, therefore, that psychopathy cannot be conceptualised in terms of any of the four attachment styles as measured by the RAAS and RSQ (secure, preoccupied, fearful, dismissing) and within the two broad categories, namely anxious and avoidant. Indeed, no current insecurity of attachment was able to predict psychopathy. This hypothesis is in accordance to Gacono and Meloy's (1991) findings; they found that psychopaths were less able to form attachments compared to non-psychopaths. The study findings with regard to the

relationship between attachment and psychopathy may indicate that we need to develop new measures to assess the quality of attachment in psychopathic patients.

Severe early relational trauma appears to interrupt the biopsychosocial behavioural system of attachment and the child cannot develop proximity to its maternal object. External trauma affects the intrapsychic representation of significant others and causes failures of internalisation as the child cannot normally internalise the mother. He either attacks, devours or kills the mother to deny dependency at all costs. Neurobiological findings seem to suggest that the absence of attachment in psychopathy is rooted in chronic cortical under-arousal and the peripheral autonomic hypo-reactivity to aversive stimuli (Meloy, 2005). Our findings are also in accordance with Blair, Mitchell & Blair (2005) who hypothesised that attachment abnormalities in early childhood cannot be considered sufficient causal factors for the development of psychopathy.

Although there is no correlation between psychopathy and attachment, sexual sadists, as well as sadistic psychopaths appeared to be more dismissive. From a psychoanalytic point of view, the findings of this study, along with prior research, seem to suggest that there are two different types of criminal psychopathy, namely the hostile and the sadistic psychopathy. It has been argued that sadistic psychopathy is a more severe form of hostile psychopathy and it reflects a mode of object relations where the sadistic psychopath is engaged in transference re-enactments of old traumatic events in which his victims stand for key figures from the past.

Arguably, therefore, sadistic psychopathy does not involve the total absence of object relations which is notable in hostile psychopathy. This theoretical hypothesis could possibly explain the finding that sadistic psychopaths were found to be more dismissing compared to non-sadistic psychopaths. A dismissing-avoidant attachment style reflects a positive view of one's self and a negative view of others. The desire for independence is crucial for the

dismissive person, who views himself as self-sufficient, as someone who can 'manage alone' without others.

Interview narratives revealed that sadistic psychopaths had suffered severe trauma and betrayal by their significant others. Nobody was around to offer help and support, so they had to 'manage alone'. Given his severely traumatic environment, the sadistic psychopath has lost all his confidence that help will be forthcoming. He is enslaved in a pseudoautonomous inner world, his grandiose self-structure in which he attempts to live. As much as the sadistic psychopath does not want others, at the same time, he needs others whom he aggressively devalues to maintain his narcissistic equilibrium. As Otto Kernberg (1989, as cited in Meloy, 2001) best put it: 'The antisocial personality's reality is the normal person's world of nightmares; the normal person's reality is the nightmare of the psychopath' (p. 335).

CHAPTER 7

CONCLUSIONS

7.1 Concluding comments

The present thesis has aimed to investigate the role of early environmental antecedents, namely attachment insecurity, aversive childhood experiences and early relational trauma in the constructs of psychopathy and sexual sadism. Furthermore, this thesis intended to explore the extent to which these early developmental antecedents and psychogenic factors related to violent, sexually violent and sadistic behaviour. The study also had two additional objectives: to investigate the relationship between sexual sadism and psychopathy; and to research whether sadism is a key trait within the construct of psychopathy.

In other to address these questions and to meet the objectives of the study a mixed-method approach was followed. In conclusion, it was found that both sexual sadism and trait sadism are associated with psychopathy. This finding appears to support the psychoanalytic hypothesis of the existence of a more severe manifestation of psychopathy, namely sadistic psychopathy.

Furthermore, it was found that early traumatic experiences predicted psychopathy and sexual sadism and they both appeared to contribute differently to the development of the two constructs. Amongst the traumatic experiences most central to psychopathy and sexual sadism was neglect, abuse, parental humiliation as well as parental acts of cruelty. In particular, the current research implies that early relationships with primary care givers serves as one of the foundations of psychopathy and sexual sadism and provide further aetiological assumptions about how the parental objects are internalised and constitute the psychopath's and sadist's internal world – a world that is dominated by intense suffering and pain. It was

hypothesised that sadistic aggression in the construct of psychopathy is a psychic retreat as the psychopath desperately wants to ward off feelings of helplessness and vulnerability by exercising omnipotent control over their victims.

To understand the psychopathic patient, however, we need to understand their interpersonal history; their enigmatic behaviour (Hare, 2003), their complex neurobiology (Blair, 2010) and their psychodynamics (Meloy, 2001). If the foundation of psychopathy is built on "bad genes" and "bad environment' (Stone, 2009), its important future research to shed some light on how the neurobiological and environmental antecedents are intertwined. From a theoretical point of view, when a child is born with a neurobiological predisposition to psychopathy and sadism and meets a harsh parental environment, this may facilitate the development of a psychopathic or sadistic state of mind.

Neurobiological research suggests that psychopathic patients present abnormalities in specific areas of their brain (i.e amygdala, hippocampus), however the cause of those abnormalities is not yet known (Blair, 2001). It is hypothesised that early childhood maltreatment and disruptions of the attachment bond are instrumental in altering the neurobiology of the brain and particularly the amygdala, and thus contributing to deficits in affect regulation (e.g. Daversa, 2010). This hypothesis, however, hasn't been extensively tested, and research in this area is crucial in understanding of the interaction between genetic and developmental antecedents.

The research presented in this thesis was mainly exploratory on the environmental antecedents of psychopathy and sadism that had, to my knowledge, received very little attention and it aims to point to a number of directions for future research that will deepen our understanding of the psychopathic and sadistic personality and hopefully will contribute to the development of more effective psychotherapeutic strategies for these patients.

7.2 Limitations and future directions

This study was not without limitations. One of the most important limitations related to the psychopathy diagnosis. Although the assessment of psychopathy was based on the PCL-R, which is considered the gold-standard instrument for assessing the disorder, the researcher was unable to obtain facet and factor scores as they were not included in patients' medical files. This occurred because the researcher had to rely on existing clinician-rated criteria for psychopathy for the PCL-R. Future studies should aim to explore whether and specifically how different PCL-R facets are related to particular forms of trauma and attachment styles.

The second important limitation with regards to psychopathy diagnosis is PCL-R's categorical approach. As was mentioned in the second chapter of this study, the PCL-R adopts a categorical approach to the measurement of psychopathy, classifying offenders as either psychopaths or non- psychopaths (i.e. having a score equal to or greater than 30 in the US, or 25 in Europe). In this study the European cut off score of 25 was adopted strictly for research purposes, and study participants were classified as either 'psychopaths' (i.e. violent and/or sexually violent patients who had a PCL-R score equal to or greater than 25), or 'non – psychopaths' (violent and/or sexually violent offenders who scored less than 25).

There has been an ongoing debate on how psychopathy is best defined and measured (see chapter 2). There is also an ongoing debate about the core traits of psychopathy, with the main controversy of this debate concerning criminal and antisocial behaviour as core traits of psychopathy. Therefore, the PCL-R categorical diagnosis of psychopathy has been subject to criticism, and several clinicians and researchers have opposed to this categorical approach (e.g., Stone, 2009) or others suggested that different PCL-R scores reflect different levels of psychopathy (e.g., Meloy, 2001). The psychoanalytic understanding of psychopathy goes

beyond the categorical approach, and conceptualises the construct as a continuum rather than a category (e.g., Kernberg, 1980; Juni, 2010).

The categorical approach to psychopathy may have also negatively affected the recruitment process. Several patients declined to participate when they read the words 'psychopathy' and 'sadism' reflected either on both Participant Information Sheet (PIS) Consent Form (CF). This was one the main reasons that discouraged several participants to take part in the study, and is probably related to the diagnostic label of psychopathy and sadism, which is an outcome, I think, of the categorical approach (i.e., psychopath/non-psychopath, sadist/non-sadist). Three patients in particular dropped out from the study as it was 'too much' and they felt that the study had 'nothing to do with them'. This raises an important research as well as clinical issue, namely how patients respond to diagnostic labels, which may have implications on their treatment and it needs to be taken into consideration; an extensive discussion of this issue, however, is beyond the scope of this study.

Another limitation of this study was the use of self-report measures. This is a common problem that researchers encounter when working with psychopathic participants. Although this method was chosen as it was considered the most practical, there is little doubt that self-report measures are associated with numerous problems. First, there is the issue of response bias. Psychopaths are notorious 'liars par excellence' and they present a tendency to con and manipulate researchers. As a result, no self-report measure has been proven accurate enough to depict the dynamics of the psychopathic and sadistic personality, as well as to assess their interpersonal relationships.

Second, there is the question of validity in these scales. For example, the results indicate that trait narcissism was not associated with either psychopathy or sexual sadism. This finding contradicts the hypotheses and findings of previous studies that seem to suggest that psychopaths are more pathologically narcissistic compared to non-psychopaths. It is

either that there are limited narcissistic traits in psychopathy and sadism, or the NPI-16 fails to measure those traits in this population. Moreover, the NPI's low Cronbach α, raises questions about the validity of the self-report and its capacity to capture narcissistic traits within a forensic mental health population of violent and sexually violent psychopathic and sadistic patients. Indeed, these findings raise an underlying issue and point to the necessity of replicating the findings by using a more accurate assessment of narcissism.

The findings of the study have served to raise a number of questions with regard to the use of attachment scales used in this study. Given that neither the Relationship Scale Questionnaire (RSQ) nor the Revised Adult Attachment Scale (RAAS) predicted any attachment insecurity in psychopathy, it is either the case that there are no insecurities of attachment in the construct or the two self-reports failed to measure attachment insecurities in forensic mental health patients. A working hypothesis with regard to this failure was proposed in Chapter 6.

There are also a number of issues surrounding the sample used in this thesis. Only male participants took park in this study and this calls into question the generalisability of the current findings for females. Although psychopathy is found in both men and women, Hare (1991) proposed that psychopathy might be expressed differently in females. Indeed it is currently unknown whether females possess the same underlying traits of psychopathy, or whether those psychopathic traits differ or expressed differently among males and females. On the other hand, it would be difficult to examine, for example, the comorbidity between sexual sadism and psychopathy as sexual sadism is very rare in females (Stone, 2009). Future research, however, should aim to explore the early developmental antecedents of psychopathy in female forensic mental health patients and test the underlying differences between the two sexes. Arguably, therefore, the data from this study cannot be generalised to female patients.

Another possible issue with the present sample is that resulting from the absence of cross-cultural differences. Indeed, all the participants in the study were British in origin. Although research on psychopathy has indicated that findings are relatively similar across cultures (Cooke et al., 2005), it is still uncertain if data can be generalised to different populations. Furthermore, this study was carried out among a homogenous group of forensic mental health patients. The homogeneity of the group raises questions with regard to the replication of the findings of the study among non-forensic populations.

A clear area for expansion of these results is to consider successful psychopathy. The current study focused on criminal psychopathy and forensic sexual sadism as it aimed to explore how the developmental antecedents are related to violent and sexually violent behaviour. It not clear, however, if the same developmental factors are able to predict successful psychopathy which is characterised by the same affective deficits. Future studies could consider the role of early relational trauma and attachment insecurity in successful psychopaths. A further area of future research would be, similarly, to look at the relationship between sadistic traits and successful psychopathy.

Finally, with regard to identified limitations, an important path of further research is the replication of the findings of this study by using non self-report measures. Further research using clinician-rated measures for narcissism, trait sadism and attachment insequrity is necessary to support the validity of these findings. As such, another avenue for future research is to consider the development and validation of appropriate alternatives to self-report measures, such as behavioural scales for the assessment of narcissism, attachment orientations and sadistic traits. Nevertheless, replication of these results using validated alternatives to self-report measures would be an important step for this research.

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APPENDIXES

Appendix 1: Research Protocol

Early developmental mechanisms predicting psychopathy and sexual sadism amongst forensic mental health patients

Research Protocol, Version 3.4

25th February, 2019

Full Title	*Early developmental mechanisms predicting sexual sadism and psychopathy amongst forensic mental health patients*
Short Title/Acronym	*Developmental antecedents of psychopathy and sexual sadism*
Sponsor	Queen Mary University of London
	Contact person of the above sponsor organization is:
	Dr Mays Jawad *Joint Research Management Office* *5 Walden Street* *London* *E1 2EF* *Phone: 020 7882 7275* *Email:* research.governance@qmul.ac.uk
REC Reference	*17/EM/0282*
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Insert as applicable list of *Sites:*

West London Mental Health Trust (WLMHT)

East London Foundation Trust (ELFT)

Oxford Health NHS Foundation Trust

Contents Page

1. GLOSSARY of Terms and Abbreviations

ASP	Assessment of Sadistic Personality
APD	Antisocial Personality Disorder
CI	Chief Investigator
DSPD	Dangerous and Severe Personality Disorder programme
DSM-V	Diagnostic and Statistical Manual of Mental Disorders 5th edition
ICD-10	International Classification of Mental and Behavioural Disorders, 10th edition
ICF	Informed Consent Form
NHS	National Health System
NPD	Narcissistic Personality Disorder
NPI-16	Narcissistic Personality Inventory -16
NHS REC	National Health Service Research Ethics Committee
Participant	An individual who takes part in a clinical trial
PCL-R	Psychopathy Checklist – Revised
PCL: SV	Psychopathy Checklist Screening Version
PI	Principal Investigator
RAAS	Revised Adult Attachment Scale
REC	Research Ethics Committee
RSQ	Relationship Scales Questionnaire
SESAS	Severe Sexual Sadism Scale
TEC	Traumatic Experience Checklist
UKCP	UK council for psychotherapy

WHO World Health Organization

2. SIGNATURE PAGE

Chief Investigator Agreement

The clinical study as detailed within this research protocol **(Dated 25/2/19)**,or any subsequent amendments will be conducted in accordance with the Research Governance Framework for Health & Social Care (2005), the World Medical Association Declaration of Helsinki (1996) and the current applicable regulatory requirements and any subsequent amendments of the appropriate regulations.

Chief Investigator Name: Mr Theodoros Papagathonikou

Chief Investigator Site: Queen Mary University of London

Theodoros Papagathonikou

Signature and Date: 25/02/19

3. SUMMARY/SYNOPSIS

Title	*Early developmental mechanisms predicting psychopathy and sexual sadism amongst forensic mental health patients*
Methodology	*Mixed-method design involving questionnaires and semi-structured interviews*
Research Sites	*West London Mental Health Trust (WLMHT)* *East London Foundation Trust (ELFT)* *Oxford Health NHS Foundation Trust (OHNFT)*
Objectives/Aims	*Brief statement of key primary objectives*
Number of Participants/Patients	*77 participants*
Main Inclusion Criteria	*Participants will be service users in the personality disorder services within high and medium secure hospitals and allocated to a secure mental health service as part of their pathway plan and treatment*
Statistical Methodology and Analysis (if applicable)	*This study will involve a mixed-method approach and is divided in two stages.*

	The initial stage will involve quantitative research methods and has two components. First, the relationship between psychopathy and sexual sadism will be examined in a group of violent and sexually violent service users. *The next stage will be investigation of potential traumatizing experiences in the aforementioned group of service users.* *In the final qualitative stage of the study semi-structured interviews will be conducted. The data from the qualitative interviews will be analysed by means of thematic analysis.*
Proposed Start Date	4/9/2017
Proposed End Date	3/9/2019
Study Duration	*24 months*

4. INTRODUCTION

The Construct of Psychopathy

Psychopathy is a deviant developmental disorder characterized by emotional deficits (Blair, 2013), an excessive amount of instrumental aggression (Meloy, 1992) and has been associated with violence, crime and antisocial behaviour (Hare, 2003). The construct of psychopathy was first operationalized by Hervey Cleckley, in his seminal work *The Mask of Sanity* (Cleckley, 1964). In contrast to the common idea that the psychopath is simply an insane criminal, Cleckley's conceptualization of psychopathy was predominately based on the understanding of psychopath's emotional and internal world rather than his antisocial and felonious behaviour (Kring, Davinson, Neale & Johnson, 2010). Following Cleckley's approach, psychopathy has been more recently modified and operationalized by Robert Hare, who defined psychopathy as a constellation of interpersonal, affective and lifestyle characteristics (Hare, 1993). In a psychodynamic elaboration, Otto Kernberg (1975) and Reid Meloy (2002) offered a psychoanalytic insight of psychopathy based on object relations theory[7] and primitive defense mechanisms.

Psychopathy and Sexual Sadism

Psychopathy and sexual sadism are mental disorders that have often been associated at a theoretical and a clinical level (Holt, Meloy, & Strack, 1999). Both constructs have also been empirically linked to predatory violence (Robertson & Knight, 2014), sexual offending and sexual homicides (Porter, Woodworth, Earle, Drugge, & Boer, 2003), as well as to non-

[7]Object relations is a psychoanalytic theory that emphasizes on very early interpersonal relations with significant others (in particular within the family) and on how these interpersonal interactions build a personality structure which determines the quality of the future relationships with other people later in someone's life (Mitchell and Black, 2016)

sexual violence. According to the psychoanalytic approaches the two forensically related disorders share a primitive object relations structure (Meloy, 2001); emotional detachment from the suffering of the others (Mokros, Schilling, Eher, & Nitschke, 2012); instinctual aggression; and an absence of object relational capacity to bond (Juni, 2009)

Despite the theoretical overlap and the interrelation of psychopathy and sadism, the empirical correlation and measurement of the relationship between the two constructs is very rare throughout the scientific literature. Furthermore, we lack a profound understanding of the life course of psychopathy and sadism. On the Hippocratic principle that "prevention is better than cure", we argue that the only way to prevent a disorder is to deeply understand it by finding its roots and unraveling the developmental mechanisms that can lead to this disorder.

To understand a mental disorder, we need to find out why and how the pathology causes behavioral deviance (Blair, 2012). With regards to psychopathy, neuroscience has made significant contributions to our understanding of psychopath's brain and there is a growing body of research which supports the genetic, psychobiological and neurobiological foundation of psychopathy (Blair, 2013; Viding, Blair, Moffitt, & Plomin, 2005). However, the fundamental causes of the psychopathic disturbance remain unclear and there is a little consistency in identifying the early developmental pathways that underpin the development of the psychopathic personality (Robertson and Knight, 2014). The lack of understanding of the psychopathic state of mind is in congruence with the current conceptualization of psychopathy as a static personality disorder. Equally, the scarcity of the research on how early developmental antecedents impact upon adult personality development in individuals who are psychopathic is probably the "Achilles heel" of an empirically supported treatment for both psychopathy and sadism.

This research is based on the hypothesis that psychopathy and sadism have a psychobiological substrate, but aims to expand this hypothesis and focus more on the developmental trajectory. Considering the lack of understanding as well as an empirically supported treatment for psychopathy and sadism this study aims to shed some light on the psychopathic enigma by finding more constructive ways to address the problem. One possible way is to research the early etiological mechanisms that explain the psychopathic and sadistic behaviour, namely how early developmental processes impact upon adulthood in individuals who are psychopathic and sadistic. Secondly, to investigate how the psychopath relate themselves with "the other". Indeed, psychopaths relate to the others through omnipotent control and domination, pattern we also find in the sexual sadist, where sexuality is intertwined with aggression.

5. RESEARCH QUESTIONS

The study is sought to answer the two following research questions:

- *Which are the early developmental mechanisms and traumatizing events that predict psychopathy and sexual sadism?*
- *To what extend do they impact upon adult personality development in individuals who diagnosed with psychopathy and sadism?*

6. OBJECTIVES

The primary task of this research is to investigate the early developmental and etiological pathways that could potentially explain and predict psychopathic and sadistic behaviour in a forensic mental health population of violent and sexually violent participants. It aims to provide an explanation of how these antecedents are dynamically present in psychopathic and sadistic participants.

There are four primary objectives:

1) To research whether or not, and to what extend early traumatic and aversive experiences are related to psychopathy and sadism.

2) To examine the association between attachment abnormalities, psychopathy and sadism.

3) To examine the relationship between psychopathy and sexual sadism in the sample of violent and sexually violent service users. This objective has also a secondary one: to examine the association between psychopathy and trait sadism in the same group of service users.

4) To examine whether the presence of psychopathy and sadism predict narcissism.

7. METHODOLOGY

Overview

The study is primarily designed to look at the early developmental and etiological pathways, such as attachment insecurity, early relational trauma, parental dysfunction, narcissism and negative care childhood experiences that impact upon adult personality development in patients who are psychopathic and sadistic. To do this, we will conduct a study which is divided in two stages in the following order:

1. An investigation of the relationship between psychopathy and sadism in a sample of violent and sexually violent service users.

2. An investigation of the association between the early developmental antecedents, such as attachment insecurity, narcissism, early childhood trauma and aversive childhood experiences amongst violent and sexually violent service users.

First, in order to empirically assess the relationship between psychopathy and sadism we will try to assess both constructs as accurately as possible. The assessment of psychopathy will be based on the existing, clinician - rated classification criteria of all four facets of the Psychopathy Checklist-Revised (Hare, 1993, 2000) and/or Psychopathy Checklist: Screening Version (Hart, Cox and Hare, 1995). If no PCL-R or PCL:SV scores are available then the researcher will screen participants' collateral information by using the PCL:SV. Trait sadism will be measured through the administration of the 20-item *Assessment of Sadistic Personality* (ASP; Plouffe, Saklofske & Smith, 2017).The assessment of sexual sadism will be based on the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Axis 1 criteria for sexual sadism*, (Diagnostic and statistical manual of mental disorders, 2013) *and/or on the International Classification of Mental and Behavioural Disorders, 10th edition* (The ICD-10 classification of mental and behavioural disorders, 1992*),* as well as on the *Severe Sexual Sadism Scale* (SESAS; Nitschke, Osterheider, & Mokros, 2009), a validated instrument that evaluates sexual sadism through 11 items that describe sadistic fantasies and behaviours.

Items in the Severe Sexual Sadism Scale (SESAS; Nitschke, Osterheider, & Mokros, 2009)
1. Offender is sexually aroused by sadistic acts 2. Offender exercises power/control/domination over victim 3. Offender humiliates or degrades the victim 4. Offender tortures victim or engages in acts of cruelty on victim 5. Offender mutilates sexual parts of victim's body 6. Offender engages in gratuitous violence or wounding toward victim 7. Offender keeps records (other than trophies) or trophies (e.g., hair, underwear, ID) 8. Offender mutilates nonsexual parts of victim's body 9. Victim is abducted or confined 10. Evidence of ritualism in offense 11. Insertion of object into bodily orifices

In the second stage of the study, we will research the role of the early developmental antecedents, such as attachment insecurity, narcissism, early trauma, pain and negative care childhood experiences, which potentially impact upon adult personality development in psychopathic and sadistic individuals. It is hypothesized that a high level of early relational trauma, insecure attachment and severe maltreatment in childhood are associated with sadistic violence and higher psychopathic scores. The aforementioned relationship will be empirically assessed through the administration of four self-report measures, namely the *Traumatic Experience Checklist* (TEC; Nijenhuis, Hart and Kruger, 2002); *Revised Adult Attachment Scale* (RAAS; Collins & Read, 1990*)*;

Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994) and the *Narcissistic Personality Inventory -16* (NPI-16; Ames, Rose & Anderson, 2006) in the sample of violent and sexually violent participants.

In the third and final stage of the study we will conduct semi-structured qualitative interviews. Those 12 psychopathic participants with the lowest and highest scores in the *Assessment of Sadistic Personality (ASP)* will be invited to an interview. This will allow us to explore the function of violence in those both with and without significant sadistic traits; identify the early developmental antecedents which could predict sadism and psychopathy; and examine whether traumatizing experiences contributing to the development of psychopathy through the subjective experience of each participant.

Inclusion Criteria

The sample for the study will be comprised by 77 participants and will be done at an institutional level. Specifically, high and medium secure forensic mental health services of the National Health System (NHS) will be selected for inclusion within the study, which formerly housed DSPD Programs. Sampling selection will be based on the following inclusion criteria:

Inclusion criteria related to offending background:

1) Being a service user who had committed violent offences, meeting the definition of violent behaviour[8] set by the World Health Organization, (Krug et al, 2002).

[8]"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Krug et al., 2002, pp. 5)

2) Being a service user who committed sexually violent offences, as they are defined by the Sexual Offences Act (2003) and the World Health Organization[9] (WHO).

3) Being an offender who allocated to a secure mental health service, or who was also formerly in a DSPD program.

Exclusion criteria related to the individual participants in the study:

1) Service users who committed non-violent offences, e.g. fraud.

2) Non –English speakers, who will have difficulties to understand the Participant Information Form and participate in the interview without an interpreter.

Study Design / Plan – Study Visits

Each identified secure mental health service within the study will receive three study visits:

1) In the initial study visit, the aim is to conduct participant screening via consultation with the responsible clinician at the service, obtain consent and systematize information from the participant's clinical notes and files.

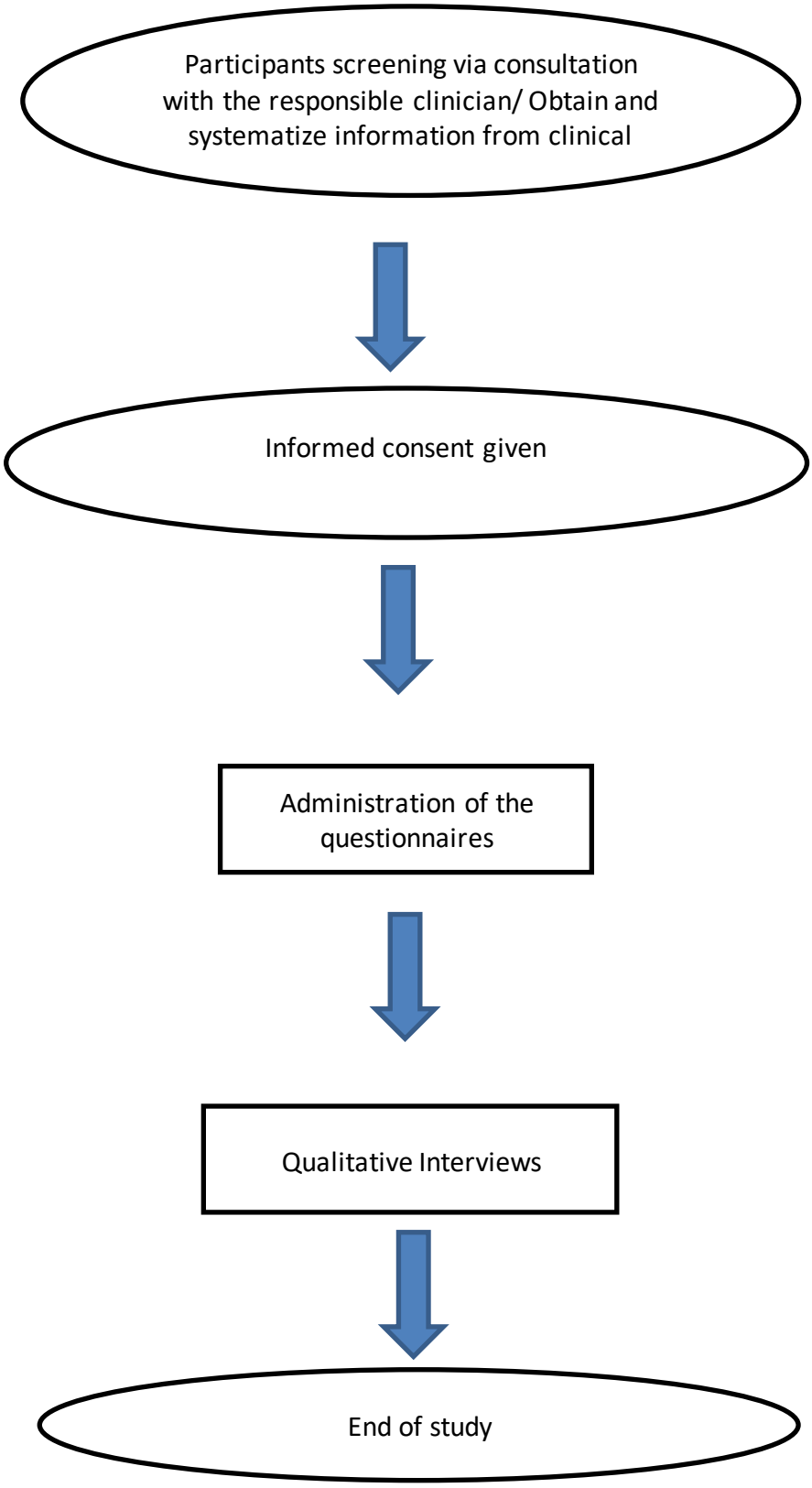
2) In the second study visit, one month after the initial visit, we will conduct the administration of the questionnaires.

3) In the third and last study visit, between one and three months after the second visit, we will conduct the qualitative interviews.

[9]"Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (Krug et al., 2002, pp. 149)

Figure 1

Study Scheme Diagram



8. STUDY PROCEDURES

A description of the following should be included as applicable

This will be a mixed - method study and is divided in two stages. The first one considers the relationship between sexual sadism and psychopathy and investigates whether or not the former is a trait of the later. Secondly, the study aims to shed some light on the developmental antecedents of psychopathy and sadism by researching whether or not, and to what extend these antecedents are impact upon adult personality development in those participants.

Screening and Enrollment

The participants who meet the inclusion criteria for the study will be initially identified through file review and then by consultation with the responsible clinician in each secure forensic mental health hospital. The responsible clinician will indicate whether there are any participants who do not have the capacity to give informed consent, and identify those who meet the exclusion criteria set for the study.

The size of the sample for the study will be 77 violent and sexually violent service users.

Informed Consent Procedure

Informed consent will be sought from all participants, and will be gathered for both the quantitative and qualitative components of the study. The consent form will initiate and inform them about the purpose of the study and it will contain details in relation to their involvement. Next, the responsible clinician will identify the sample of service users according to the above-mentioned criteria, discuss the research project with them and obtain the initial agreement to participate in the study. Yet, the participants will be

approached by the lead researcher, who will distribute the consent forms and supply them with an information form. Potential participants will be given 24 hours to consider their involvement, and the completed consent forms will subsequently be collected by the researcher in collaboration with local staff members. One copy of the signed consent form will be kept on file and one will be given to the participant.

The participants will be adequately aware of the purposes and details of the study, the anticipated benefits and potential risks, and the discomfort the study may entail along with appropriate actions in such circumstances and their right to abstain from participation or withdraw consent to participate at any time without reprisal.

Procedure for collecting data

This study is a mixed-method study and has both quantitative and qualitative components. However, the sampling procedure for collecting quantitative and qualitative data does not differ for both components.

The quantitative stage of the study has a twofold aim. First, it will investigate the relationship between psychopathy and sadism and test whether sadism is a trait of psychopathic disorder in a group of 77(n=77) violent and sexually violent participants. Second, it will research potential traumatizing events and attachment insecurity in the same group of participants.

1) To measure sexual sadism, we will follow the DSM V, Axis 1 criteria for sexual sadism and/or the ICD 10 criteria for sadomasochism, and also we will code service user's clinical notes based on a set of 11 criteria for severe sexual sadism, according

to the *Severe Sexual Sadism Scale (SESAS).* The assessment of sadism as a trait will be based on the *Assessment of Sadistic Personality (ASP).*

2) Potentially traumatizing events, including emotional neglect, emotional, physical and sexual abuse, sexual harassment and bodily threat from a person will be assessed through the administration of the *Traumatic Experience Checklist* (TEC), which provides a separate score for each of the aforementioned traumatic events. Attachment pathologies will be measured through the *Revised Adult Attachment Scale* (RASS) and *Relationship Scales Questionnaire* (RSQ); narcissism will be measured through the *Narcissistic Personality Inventory -16 (NPI-16).*

In the qualitative part of the study, we will conduct semi-structured individual interviews. Within the sample of 77 participants, those 12 participants, who diagnosed with psychopathy, with the highest and lowest scores on the *Assessment of Sadistic Personality (ASP)* will be approached for interview, to a total of 24 interview participants. This will allow us to explore the function of violence in those both with and without significant sadistic traits; identify the early developmental antecedents which are potentially associated to sadism and psychopathy; and to examine the traumatizing experiences contributing to the development of psychopathy through the subjective experience of each participant.

Considering that lying, conning and manipulating are specific clinical features of psychopathic patients, sometimes self-report methods, despite their effectiveness, can be insufficient to accurately measure a trait due to the low 'true positive' rate. For that reason the individual interviews (in conjunction with the self- report measures) will make the research more robust in terms of clinical assessment and provide us more detailed information.

Subject withdrawal

Participants will be informed in the consent form about their right to withdraw from the research at any time. However, because of the anonymity of the participants it might not be practical for the researcher to withdraw the individuals' data after a certain point and this will be made clear at the consent stage.

End of Study Definition

The study will be considered to have ended when the prerequisite number of participants have been recruited and interviewed during the second and last stage of the study, or when time for data collection is up in September 2019, whichever is sooner.

9. STATISTICAL CONSIDERATIONS

Sample Size

The sample size for the study was selected based on researcher's defined selection criteria. Participants will be service users in the personality disorder serviceswho allocated to secure mental health services as part of their pathway plan and treatment. Medium and high secure forensic mental health services within the National Health System (NHS) will serve as the recruitment sites for the study.

For the *quantitative* part of the study, we aim to recruit a sample of 77 participants (n=77) who had been convicted for violent and sexually violent crimes. Service users will be classified as *violent* if they had never committed a sexual crime but had been convicted for crimes, such as manslaughter, murder or attempted murder, physical injury, or assault; and as

sexually violent if they had convicted for a sexual offence as they defined by the Sexual Offences Act (2003). Despite the type of conviction, the service user will be classified as sexually violent if his offence had sexual and/or sadistic elements. Any gender or ethnic restrictions in reference to the selection of the service users were not implied for this study.

For this project, relationships between the *Revised Adult Attachment Scale* (RASS) *Severe Sexual Sadism Scale* (SESAS), *Assessment of Sadistic Personality* (ASP), *Narcissistic Personality Inventory* (NPI), *Relationship Scale Questionnaire* (RSQ), the Traumatic Experience Checklist (TEC), and the *Psychopathy Checklist Revised* (PCL-R) will be explored through a series of multiple linear regressions. First, the relationship between sexual sadism, trait sadism and psychopathy will be examined. In this objective, the SESAS, the ASP and their interaction are predictor variables and the PCL-R is the dependent variable. The main effect of SESAS, the main effect of ASP, their interaction effect and their overall effect will all be used to predict psychopathy (PCL-R).

The next objective examines the effect of attachment abnormalities and sexual sadism, psychopathy and trait sadism. This research question uses the RAAS, the RSQ, and their interaction as predictor variables in three linear regression equations: one with the SESAS as the dependent variable, one with the PCL-R as a dependent variable, and one with the ASP as the dependent variable. The main effect of RAAS, the main effect of RSQ, their interaction effect and their omnibus effect will all be tested on the SESAS, the PCL-R and the ASP.

Third the study will explore the relationship between psychopathy, trait sadism, sexual sadism and the adverse childhood experiences. This research question uses the SESAS, the ASP, the PCL-R, and their interaction as predictors in a linear regression equation with TEC as a dependent variable. The main effect of SESAS, the main effect of PCL-R, their

interaction effect and their overall effect will all be tested to predict the presence of adverse childhood experiences.

To examine the relationships between psychopathy, sexual sadism, trait sadism and trait narcissism, the PCL-R, the SESAS, the ASP and their interaction will be the predictor variables and the NPI-16 will be the outcome variable. The main effect of PCL-R, the main effect of ASP and SESAS, their interaction effect and their overall effect will all be tested to predict narcissism (NPI-16).

Power analyses indicate that for each research question, 77 participants will be necessarily for a sufficiently powered (.80) analyses to detect a small (.15) effect size. Descriptives and frequencies for research and demographic variables will be computed, and a correlation matrix of the research variables will be calculated to describe the variables' co linearity. Research variables will be plotted in frequency distribution histograms to examine normality and check for outliers. The research questions will then be addressed using the six linear regression equations. To determine significance, a p-value of .05 will be used. All tests will be performed in SPSS.

For the qualitative part of the study, we aim to interview 24 participants. Within each study site, the participants who have been diagnosed with psychopathy (PCL-R>25), with the highest and lowest scores on the Assessment of Sadistic Personality (ASP) will be approached for interview, to a total of 24 interview participants across all sites. This will enable us to explore the function of violence in those both with and without significant sadistic traits, as well as to achieve 'concept saturation' within both sadistic and non-sadistic participants.

Method of Analysis

This is a mixed- method study, therefore different methods of analysis will be implemented for each component of the study. For the quantitative part of the study, all statistics will be conducted using *SPSS* version 23 for Windows. An alpha (α) level of p=0.05 will be adopted throughout.

The method of analysis for the qualitative part of the study will be based on thematic analysis. Data will be analysed using *NVivo* version 10 qualitative data analysis software for Windows.

10. ETHICS

This is a research project conducted with service users within a security forensic mental health hospital in England, so it will require review by an appropriate NHS Research Ethics Committee (REC) and approval from the Health Research Authority (HRA).

We will seek informed consent from all the service users and undertake not to use any identifiable information about them in any subsequent publication, report or other derivative from the study. We will also check with the responsible clinician whether there are capacity concerns about any of the potential service users and we will exclude them from the study. We will consider and promote the privacy and participants' rights throughout the study, as they may feel coerced to participate or fear that their information will be shared with others. To address this issue, the researcher will try to establish a positive rapport with the research participants in order to earn their trust and respect. To do

that the researcher will seek informed consent from all the participants and will not use any identifiable information about them. However, in the event criminal or other disclosures which warrant further action occur, the researcher, as he clearly stated in the consent form, is obliged to relay this information to the staff team. Regarding the qualitative individual interviews, the researcher will request the interviews to be conducted in private, without the presence of staff or other service users. All interviews will be transcribed using pseudonyms and the consent forms will be stored in a secure cabinet within a locked area in the Centre for Psychiatry, Queen Mary University of London.

The aim of this study is to investigate the early etiological mechanisms which could potentially predict the development of psychopathic and sadistic behaviour. For that reason emphasis is given on early relational trauma, severe maltreatment in childhood, sexual, physical or emotional abuse by the caregivers, parental dysfunction, gross neglect as well as any painful experiences in general. As a consequence, there is profound focus on individuals' psychopathology and on experiences which may be traumatic. Despite the fact that previous research has shown that psychopathy is negatively correlated with empathy and psychopaths do not have the ability to experience emotions in depth (Hare, 2003; Mullins-Nelson et al. 2006), the research design is such that service users are likely to be exposed to a degree of emotional pressure and distress, while they will be uncovering painful experiences.

The researcher acknowledges that sensitive topics will be explored during the study and for that reason several strategies will be implemented to protect the participants. First, the emotional reactions of each participant will be closely monitored. Secondly, a mental health professional will be alerted in advance of any contact with the patient and he/she will be standing by to provide the necessary support in case is needed. Third, the

researcher will encourage the participants to take frequent breaks during the stressful parts of the interview and he will remind them that they have the right to withdraw from the research at any stage. Fourth, the researcher will provide the participants with the necessary information on the available psychological and support services. The interviewer is a UKCP trainee psychoanalytic psychotherapist and he will be able to identify psychological distress during the interview and take the appropriate steps to mitigate it.

11. SAFETY CONSIDERATIONS:

Every research project conducted in a forensic environment involves a number of minor risks to the researchers and therefore this study will not be an exception. This project is conducted within secure forensic mental health hospitals, including service users who were formerly part of the Dangerous and Severe Personality Disorder (DSPD) programme. Furthermore, the design of the research involves conduct with service users who have displayed severe physical or sexual violence and been convicted for offences such as assault, rape, murder or attempted murder, manslaughter or sexual homicides. Consequently, it could be a minor risk of aggression or violence from service users.

To alleviate this concern, the researcher will attend the security induction and follow the safety and the security protocols of the hospital. The researcher will receive personal support and monthly supervision by his supervisors, who are very experienced in conducting research with forensic service users and they can provide adequate support and guidance. The researcher is also undergoing intensive personal therapy as part of his clinical psychoanalytic psychotherapy training, which will help him to deal with the impact of possible threats of aggression and psychological violence.

12. DATA HANDLING AND RECORD KEEPING:

Data Handling

The researcher will protect and ensure the confidentiality as well as the anonymity of the participants who will be identified using pseudonyms throughout the study. During the study no personal data will be collected, apart from the consent forms, which will be stored in a secure cabinet within a locked area in the Centre for Psychiatry, Queen Mary University of London.

Record Keeping

The anonymised research data collected during the study will be stored on an encrypted cloud storage service (electronic data), namely Boxcryptor, and will be safe from any unauthorized access, accidental loss, damage or destruction. Access to the research data will be allowed only to authorized people who are directly involved, who will be the researcher and his supervisors. After the fulfilment of the study, the data will be securely archived for a further 20 years in line with the sponsor's guidelines.

13. FINANCE AND FUNDING

The researcher received no financial support and funding for the research.

14. IDEMNITY

Queen Mary University of London will be the sponsor for this study, and will provide indemnity for the researcher.

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Appendix 2: Consent Forms for questionnaires

IRAS ID: 224145

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM FOR QUESTIONNAIRES

Title of Project: **Sexual Sadism and Trauma in Psychopathy**

Name of Researcher: Theodoros Papagathonikou

Please tick the boxes below:

☐ 1. I confirm that I have had enough time to read and understand the information sheet dated **Version 3.0** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐ 2. I understand that my participation is voluntary and that I am free to withdraw at any time for any reason, without my treatment or standard of care being affected. I understand that information from the questionnaires or discussions I have already participated in will be retained by the researchers.

☐ 3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by the principal investigator and his supervisors, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

☐ 4. I agree to my Responsible Clinician being informed of my participation in the study. I agree to my Responsible Clinician being involved in the study, including any necessary exchange of information about me between my RC and the research team.

☐ 5. I understand that if I disclose information that indicates that I or another person is at risk of harm, or if I disclose information about a past offence for which I have not been convicted, the researcher is obligated to relay this information to the staff team.

☐ 6. I understand that I have to option to receive a copy of the summary study results. I understand that all the data collected from the research will be written up into a final research report. I understand that this report will not contain any identifiable details about me.

☐ 7. I agree to take part in the above research.

Appendix 3: Consent form for Interviews

IRAS ID: 224145

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM FOR INTERVIEW

Title of Project: **Sexual Sadism and Trauma in Psychopathy**

Name of Researcher: Theodoros Papagathonikou

Please tick the boxes below:

☐ 1. I confirm that I have had enough time to read and understand the information sheet **version 3.0** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐ 2. I understand that my participation is voluntary and that I am free to withdraw at any time for any reason, without my treatment or standard of care being affected. I understand that information from the interviews or discussions I have already participated in will be retained by the researchers.

☐ 3. I understand that I will be taking part in an interview and that this will be tape-recorded before being typed up for analysis. I understand that, following transcription, the tape-recording of my interview will be destroyed.

☐ 4. I understand that if I disclose information that indicates that I or another person is at risk of harm, or if I disclose information about a past offence for which I have not been convicted, the researcher is obligated to relay this information to the staff team.

☐ 5. I understand that I have to option to receive a copy of the summary study results. I understand that all the data collected from the research will be written up into a final research report. I understand that this report will not contain any identifiable details about me.

☐ 6. I agree to take part in the above research.

Appendix 4: Participant Information Sheet for Questionnaires

Sexual Sadism and Trauma in Psychopathy

PARTICIPANT INFORMATION SHEET FOR QUESTIONNAIRES (v. 3.0, 25/2/2019)

Introduction

I would like to invite you to take part in a research study. The study is a doctoral student research and therefore is towards an educational qualification. Before you decide whether you wish to participate, it is important to understand why the research is being conducted and what your participation will involve. The purpose of this Participant Information Sheet is to help you to decide whether you would like to take part in this study. Please take some time to read the following information carefully. Please do not hesitate to ask me questions if anything you read is not clear, or if there is anything that you do not understand and you would like more information about. Before you make this decision you may want to discuss with other people, and please feel free to do this. In addition, please ask me if you would like to receive further information about your participation or the purpose of the research. If you agree to take part in this study, you will be also asked to sign a Consent Form.

What is the purpose of this research?

The ultimate purpose of this research is to provide us with an understanding how sadistic violence might be related to psychopathic personality disorder. The study is primarily designed to look at early developmental issues, such as early trauma, parental dysfunction, or negative care childhood experiences that impact upon adult personality development in individuals who are relatively psychopathic and sadistic; to establish the relationship between

two personality disorders, namely sexual sadism and psychopathy; and to research the role of sadism in the construct of psychopathy.

What will I have to do in the research?

If you decide to take part in the research, you will be asked to complete five questionnaires. These questionnaires will help us to identify few character traits and whether you had experienced any traumatic experience and/or relationship problems with your primary caregivers during your early childhood. You will spend approximately 10-15 minutes to each one of the questionnaires. The total time for the completion of all the questionnaires will approximately be 60 minutes.

Do I have to participate in the research?

It is your decision whether you want to participate in the study or not. If you do decide to participate, you will be asked to sign a consent form. By signing the consent form, you will be demonstrating that you understand the research and are willing to participate. However, it is important to remember that you would still be free to withdraw from the research at any time and for any reason. If you decide not to participate or to later withdraw from the research, this will not affect your treatment or the standard of care that you receive.

If you do decide to take part in the research, then with your permission we will inform the Responsible Clinician (RC) of your involvement in the study. Once again, if you have any concerns regarding your participation please feel free to discuss it with the clinical staff.

If, during your participation in the research, your clinical team becomes concerned about your ability to consent to participate in the research, you will be taken out of the study. However,

any information you may have given in previous meetings will be kept in the research unless you specifically ask for it to be removed.

What are the possible benefits of participating in the research?

There are no guaranteed benefits to you taking part in the study. This study investigates the early developmental events that impact upon adult personality development in individuals who are diagnosed with psychopathy. The ultimate aim of the research is to provide a better understanding of the life course of psychopathy, which may help future researchers to develop treatments for the disorder. Nothing that you write in the questionnaires will have a negative impact on you. However, your contribution to the study will be extremely valuable for us and will give us greater insight and knowledge. If you wish, I will provide you with a copy of the summary of study results.

What are the possible disadvantages and risks of taking part?

There will potentially be few questions in the questionnaires which will evoke memories which are not very pleasant and might be distressing. In case you experience discomfort during the study feel free to ask for a break and also to share any difficult feelings that may have arisen.

Will my participation in this research be kept anonymous?

According to the Data Protection Act 1998, all information which is collected about you during the study will be kept strictly confidential and anonymous, and any information about you which leaves the hospital will have your name and address removed so that you cannot be recognized. Your research data, including the questionnaires you completed, will also

remain anonymous and given a research code or a number. Only the researcher will know that this code links back to you.

The researcher will protect and ensure the confidentiality as well as the anonymity of the participants who will be identified using pseudonyms throughout the study. During the study no personal data will be collected, apart from the consent forms, which will be stored in a secure cabinet within a locked area in the Centre for Psychiatry, Queen Mary University of London. The pseudonymised research data will be kept for a further 20 years after the fulfilment of the study, in line with the sponsor's guidelines.

NHS will keep your name, NHS number] and contact details confidential and will not pass this information to Queen Mary University of London. NHS will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Queen Mary University of London and regulatory organisations may look at your medical and research records to check the accuracy of the research study. Queen Mary University of London will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number or contact details.

NHS will keep identifiable information about you from this study for 20 years after the study has finished.

Who has reviewed this study?

The study has reviewed by the Leicester South Research Ethics Committee, to ensure that no physical, mental or emotional harm will come to any participants.

Queen Mary University of London is the sponsor for this study based in the United Kingdom. We will be using information from your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Queen Mary University of London will keep identifiable information about you for 20 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Queen Mary University of London will collect information about you for this research study from your medical records. Medical records will not provide any identifying information about you to Queen Mary University of London.

You can find out more about how we use your information :
http://www.arcs.qmul.ac.uk/media/arcs/policyzone/Privacy-Notice-for-Research-Participants.pdf

What if there is a problem?

If you have any concerns or questions about the study, please feel free to discuss them with your responsible clinician or other members of your healthcare team. If you are unhappy and you wish to make a formal complain, you can do this by contacting the Patient Advice and Liaison Service (PALS). I also encourage you to engage with SEAP advocacy, an independent charity which provides advocacy services and will enable your voice to be heard on issues that are important for you. Your responsible clinician will be able provide you with the contact details of these services.

Thank you very much for reading this information sheet.

Mr Theodoros Papagathonikou

Principal Investigator

Appendix 5: Participant Information Sheet for Interviews

Sexual Sadism and Trauma in Psychopathy

PARTICIPANT INFORMATION SHEET FOR INTERVIEWS (v. 3.0) 25/02/2019)

IRAS ID: 224145

Introduction

I would like to invite you to participate to the second part of the study. Before you decide whether you wish to participate, it is important to understand why the research is being conducted and what your participation will involve. Like the first one you have already completed, the purpose of this Participant Information Sheet is to help you to decide whether you would like to take part in this study. Please take some time to read the following information carefully. Please do not hesitate to ask me questions if anything you read is not clear, or if there is anything that you do not understand and you would like more information about. Before you make this decision you may want to discuss with other people, and please feel free to do this. In addition, please ask me if you would like to receive further information about your participation or the purpose of the research. If you agree to take part in this study, you will also be asked to sign a Consent Form before you start the interviews.

What is the purpose of this part of the study?

Although this is the second and final phase of the study, the aim of the research is exactly the same. It aims to provide us with an understanding how sadistic violence might be related to psychopathic personality disorder. The study is primarily designed to look at early developmental issues, such as early trauma, parental dysfunction, or negative care childhood experiences that impact upon adult personality development in individuals who are relatively

psychopathic and sadistic; to establish the relationship between two personality disorders, namely sexual sadism and psychopathy; and to research the role of sadism in the construct of psychopathy.

What will I have to do at this part of the study?

If you decide to take part in the second part of the study, I will ask you to meet with me for an interview. You have selected for the interview because your results in the first questionnaire (Assessment of Sadistic Personality) were either among the highest or lowest in your group and the interview will give us the opportunity to elaborate more on the questions you have answered in the first part of the study. The interview will involve questions which are organized into three areas. In the first one I will ask you few questions regarding the type of relationship you had with your parents and/or caregivers; in the second one you will be asked to elaborate a bit more on the questions in the first questionnaire you filled out; and in the last part of the interview you will be asked questions about the nature of and motivation for your offences. It is anticipated that the interview will last between 30 minutes and 1 hour and will take place at a time which is convenient for you and we agree together. You will also be encouraged to have a short break during the interview, if you feel it is needed. The interview will be tape-recorded so that all of the information you share can be captured accurately. I will then transcribe the interview (type up) so that I can analyse the material. Following transcription, the tape recording will be erased.

Do I have to participate in the research?

Similar to the first part of the study, it will be your decision whether you want to participate or not. If you do decide to participate, you will be asked to sign another consent form before we proceed with the interviews. By signing the consent form, you will be demonstrating that

you understand the research and are willing to participate. However, it is important to remember that you would still be free to withdraw from the research at any time and for any reason. If you decide not to participate or to later withdraw from the research, this will not affect your treatment or the standard of care that you receive.

If you do decide to take part in the research, then with your permission we will inform the Responsible Clinician (RC) of your involvement in the study. Once again, if you have any concerns regarding your participation please feel free to discuss it with the clinical staff.

If, during your participation in the research, your clinical team becomes concerned about your ability to consent to participate in the research, you will be taken out of the study. However, any information you may have given in previous meetings will be kept in the research unless you specifically ask for it to be removed.

What are the possible benefits of participating in the research?

There are no guaranteed benefits to you taking part in the study. This study investigates the early developmental events that impact upon adult personality development in individuals who are diagnosed with psychopathy. The ultimate aim of the research is to provide a better understanding of the life course of psychopathy, which may help future researchers to develop treatments for the disorder. Nothing that you mention in the interview will have a negative impact on you. However, your contribution to the study will be extremely valuable for us and will give us greater insight and knowledge. If you wish, I will provide you with a copy of the summary of study results.

What are the possible disadvantages and risks of taking part?

During the interview there will potentially be few questions which will evoke memories which can be unpleasant or distressing. In case you experience discomfort during the interview feel free to ask for a break and also share any difficult feelings that may have arisen.

Will my participation in this research be kept anonymous?

According to the Data Protection Act 1998, all information which is collected about you during the study will be kept strictly confidential and anonymous, and any information about you which leaves the hospital will have your name and address removed so that you cannot be recognized. Your research data from the interviews will also remain anonymous and be given a research code or a number. Only the researcher will know that this code links back to you.

It must be noted that if, during the interview, you disclose information that indicates you or another person are at risk of harm, I would be obligated to hand this information over to the wider staff team. Further, in the event criminal or other disclosures which warrant further action occur, or if you disclose information about a past offence for which you have not been convicted, I am obliged to relay this information to the staff team.

The researcher will protect and ensure the confidentiality as well as the anonymity of the participants who will be identified using pseudonyms throughout the study. During the study no personal data will be collected, apart from the consent forms, which will be stored in a secure cabinet within a locked area in the Centre for Psychiatry, Queen Mary University of London. The pseudonymised research data will be kept for a further 20 years after the fulfilment of the study, in line with the sponsor's guidelines.

NHS will keep your name, NHS number] and contact details confidential and will not pass this information to Queen Mary University of London. NHS will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Queen Mary University of London and regulatory organisations may look at your medical and research records to check the accuracy of the research study. Queen Mary University of London will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number or contact details.

NHS will keep identifiable information about you from this study for 20 years after the study has finished.

Who has reviewed this study?

The study has reviewed by the Leicester South Research Ethics Committee, to ensure that no physical, mental or emotional harm will come to any participants.

Queen Mary University of London is the sponsor for this study based in the United Kingdom. We will be using information from your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Queen Mary University of London will keep identifiable information about you for 20 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Queen Mary University of London will collect information about you for this research study from your medical records. Medical records will not provide any identifying information about you to Queen Mary University of London.

You can find out more about how we use your information :
http://www.arcs.qmul.ac.uk/media/arcs/policyzone/Privacy-Notice-for-Research-Participants.pdf

What if there is a problem?

If you have any concerns or questions about the study, please feel free to discuss them with your responsible clinician or other members of your healthcare team. If you are unhappy and you wish to make a formal complain, you can do this by contacting the Patient Advice and Liaison Service (PALS). I also encourage you to engage with SEAP advocacy, an independent charity which provides advocacy services and will enable your voice to be heard on issues that are important for you. Your responsible clinician will be able to provide you with the contact details of these services.

Thank you very much for reading this information sheet.

Mr Theodoros Papagathonikou

Principal Investigator

Appendix 6: Letter of HRA Approval

Health Research Authority

Mr Theodoros Papagathonikou
PhD student
Email: hra.approval@nhs.net

22 August 2017

Dear Mr Papagathonikou,

Letter of HRA Approval

Study title:	**Early Developmental Mechanisms Predicting Sexual Sadism and Psychopathy Amongst Forensic Mental Health Patients**
IRAS project ID:	**224145**
REC reference:	**17/EM/0282**
Sponsor	**Queen Mary University of London**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendix 7: QMUL Provisional Sponsorship

Dr. Sally Burtles
Joint Research Management Office
Queen Mary Innovation Centre
5 Walden Street
London
E1 2EF

Tel: 020 7882 7250
Email: Sponsorsrep@bartshealth.nhs.uk

Provisional Sponsorship

07 June 2017

Mr Theodoros Papagathonikou
PhD Candidate
Centre for Psychiatry
Queen Mary University of London
Charterhouse Square
London EC1M 6BQ

Dear Mr Papagathonikou,

Declaration of Queen Mary University of London Provisional Sponsorship

PROJECT TITLE:	**Early Developmental Mechanisms Predicting Sexual Sadism and Psychopathy Amongst Forensic Mental Health Patients**
Protocol version #:	**1.1**
Protocol date:	**01 June 2017**
ReDA Reference #:	**011870**
Host site:	**Broadmoor Hospital**

The above referenced study and supporting documentation have been reviewed and Sponsorship, as defined in the Research Governance Framework for Health and Social Care 2005 and/or the Medicines for Human Use (Clinical Trials) Regulations 2004, will be provided on the condition that the relevant regulatory body approvals are obtained and the "Conditions of Sponsorship" are adhered to.

A further declaration of formal Sponsorship will be made by the Joint Research Management Office on proof of relevant regulatory body approval/s being in place.

Please contact the Joint Research Management Office if you require any further guidance or information on any matter mentioned above.

Yours sincerely

Dr. Sally Burtles
Director of Research Services & Business Development

Cc: **Dr Mark Freestone; Prof Kamaldeep Bhui**

Appendix 8: Traumatic Experience Checklist (TEC)

T. E. C.

People may experience a variety of traumatic experiences during their life. We would like to know three things: 1) if you have experienced any of the following 29 events, 2) how old you were when they happened, and 3) how much of an impact these experiences had upon you.

A) In the first column (i.e., Did this happen to you?), indicate whether you had each of the 29 experiences by circling YES or NO.

B)For each experience where you circled YES, list in the second column (i.e., Age) your age when it happened.

If it happened more than once, list ALL of the ages when this happened to you.

If it happened for years (e.g., age 7-12), list the age range (i.e., age 7-12).

C)In the final column (i.e., How much impact did this have on you?), indicate the IMPACT (by circling the appropriate number): 1, 2, 3, 4, or 5.

1 = none

2 = a little bit

3 = a moderate amount

4 = quite a bit

5 = an extreme amount

Example:

Did this happen to you?		Age	How much impact did this have on you?
You were teased	no yes		1...2...3...4...5

Thank you for your cooperation.

	Did this happen to you?	Age	How much impact did this have on you? 1 = none 2 = a little bit 3 = a moderate amount 4 = quite a bit 5 = an extreme amount
1. Having to look after your parents and/or brothers and sisters when you were a child.	no yes	.....	1 2 3 4 5
2. Family problems (e.g., parent with alcohol or psychiatric problems, poverty).	no yes	.....	1 2 3 4 5
3. Loss of a family member (brother, sister, parent) when you were a CHILD.	no yes	.....	1 2 3 4 5

4. Loss of a family member (child or partner) when you were an ADULT. no yes 1 2 3 4 5

5. Serious bodily injury (e.g., loss of a limb, mutilation, burns). no yes 1 2 3 4 5

6. Threat to life from illness, an operation, or an accident. no yes..... 1 2 3 4 5

7. Divorce of your parents no yes..... 1 2 3 4 5

8. Your own divorce no yes..... 1 2 3 4 5

9. Threat to life from another person (e.g., during a crime). no yes..... 1 2 3 4 5

10. Intense pain (e.g., from

2!

an injury or surgery). no yes 1 2 3 4 5

	Did this happen to you?	Age	How much impact did this have on you? 1 = none 2 = a little bit 3 = a moderate amount 4 = quite a bit 5 = an extreme amount
11. War-time experiences (e.g., imprisonment, loss of relatives, deprivation, injury).	no yes	.....	1 2 3 4 5
12. Second generation war-victim (war-time experiences of parents or close relatives)	no yes	.....	1 2 3 4 5
13. Witnessing others undergo trauma.	no yes	.....	1 2 3 4 5

14. Emotional neglect (e.g., being left alone, insufficient affection) by your parents, brothers or sisters. no yes 1 2 3 4 5

15. Emotional neglect by more distant members of your family (e.g., uncles, aunts, nephews, nieces, grandparents). no yes 1 2 3 4 5

16. Emotional neglect by non-family members (e.g., neighbors, friends, step-parents, teachers). no yes 1 2 3 4 5

17. Emotional abuse (e.g., being belittled, teased, called names,

3!

threatened verbally, or

unjustly punished) by your

parents, brothers or sisters. no yes.....1...2...3...4...5

Did this happen to you?	Age	How much impact did this have on you?

1 = none

2 = a little bit

3 = a moderate amount

4 = quite a bit

5 = an extreme amount

18. Emotional abuse by more distant members of your family. no yes..... 1 2 3 4 5

19. Emotional abuse by non-family members. no yes..... 1 2 3 4 5

20. Physical abuse (e.g., being hit, tortured, or wounded) by your parents, brothers, or sisters. no yes..... 1 2 3 4 5

21. Physical abuse by more distant members of your family. no yes..... 1 2 3 4 5

22. Physical abuse by non-family members. no yes..... 1 2 3 4 5

23. Bizarre punishment no yes..... 1 2 3 4 5

If applicable, please describe:

……

……

……

24. Sexual harassment (acts

4!

of a sexual nature that

DO NOT involve physical

contact) by your parents,

brothers, or sisters. no yes 1 2 3 4 5

25. Sexual harassment by

more distant members

of your family. no yes 1 2 3 4 5

Did this happen to you? Age How much impact did this have on you?

1 = none

2 = a little bit

3 = a moderate amount

4 = quite a bit

5 = an extreme amount

26. Sexual harassment by

non-family members. no yes 1 2 3 4 5

27. Sexual abuse (unwanted sexual

acts involving physical

contact) by your parents,

brothers, or sisters. no yes..... 1 2 3 4 5

28.Sexual abuse by more distant

members of your family. no yes..... 1 2 3 4 5

29.Sexual abuse by

non-family members. no yes..... 1 2 3 4 5

30. If you were mistreated or abused, how many people did this to you?

A) Emotional maltreatment (if you answered YES to any of the questions 14-19). Numbers of persons: .....

B) Physical maltreatment (if you answered YES to any of the questions 20-23).

Number of persons: .....

C)Sexual harassment (if you answered YES to any of the questions 24-26).

Number of persons: .....

D) Sexual abuse (if you answered YES to any of the questions 27-29). Number of persons: .....

31. Please describe your relationship with each person mentioned in your answer to question 30 (e.g., father, brother, friend, teacher, stranger, etc.), and add if the person(s) was (were) at least 4 years older than you at the time when the experience(s) occurred. For example, write "friend (-)" if this friend was less than 4 years older than you. Write "uncle (+)" if this uncle was more than 4 years older than you.

A) Emotional neglect .....

.....

B) Emotional abuse .....

.....

C) Physical abuse .....

.....

D) Sexual harassment .....

.....

E) Sexual abuse .....

.....

32. Please describe any OTHER traumatic events that had an impact on you.

.....

.....

.....

33. If you have answered YES to any of the questions 1-29, how much support did you receive afterwards?

(give the number of the question and the level of support)

Question number	Level of support (0 = none, 1 = Some, 2 = Good)
.....	.....
.....	.....
.....	.....
.....	.....

You are asked to fill in and place an X beside what applies to you.

34. Age:	....	years
35. Sex:	....	female
	....	male
36. Marital status:	....	single
	....	married
	....	living together
	....	divorced

	....	widower/widow
37. Education:	....	number of years
38. Today's date	.....	/...../.....
	(day)	(month) (year)

39. Name: .....

Thank you very much for your cooperation.

Appendix 9: Revised Adult Attachment Scale (RAAS)

Revised Adult Attachment Scale (Collins, 1996)

Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.

Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1----------2----------3----------4----------5

Not at all characteristic of me — **Very characteristic of me**

1) I find it relatively easy to get close to people. _____

2) I find it difficult to allow myself to depend on others. _____

3) I often worry that romantic partners don't really love me. _____

4) I find that others are reluctant to get as close as I would like. _____

5) I am comfortable depending on others. _____

6) I don't worry about people getting too close to me. _____

7) I find that people are never there when you need them. _____

8) I am somewhat uncomfortable being close to others. _____

9) I often worry that romantic partners won't want to stay with me. _____

10) When I show my feelings for others, I'm afraid they will not feel the _____

same about me.

11) I often wonder whether romantic partners really care about me. _____

12) I am comfortable developing close relationships with others. _____

13) I am uncomfortable when anyone gets too emotionally close to me. _____

14) I know that people will be there when I need them. _____

15) I want to get close to people, but I worry about being hurt. _____

16) I find it difficult to trust others completely. _____

17) Romantic partners often want me to be emotionally closer than I feel comfortable being. _____

18) I am not sure that I can always depend on people to be there when I need them. _____

Appendix 10: Relationship Scale Questionnaire (RSQ)

RELATIONSHIP SCALE QUESTIONNAIRE (RSQ)

The RSQ can either be worded in terms of general orientations to close relationships, romantic relationships, or orientations to a specific relationship. It can also be reworded in the third person and used to rate others' attachment patterns (See Bartholomew & Horowitz, 1991 or Scharfe & Bartholomew).

Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about close relationships. (you may wish to use a 1– to 5 -point scale from *not at all like me* to *very much like me*)

1. I find it difficult to depend on other people.
2. It is very important to me to feel independent.
3. I find it easy to get emotionally close to others.
4. I want to merge completely with another person.
5. I worry that I will be hurt if I allow myself to become too close to others.
6. I am comfortable without close emotional relationships.
7. I am not sure that I can always depend on others to be there when I need them.
8. I want to be completely emotionally intimate with others.
9. I worry about being alone.
10. I am comfortable depending on other people.
11. I often worry that romantic partners don't really love me.
12. I find it difficult to trust others completely.
13. I worry about others getting too close to me.
14. I want emotionally close relationships.
15. I am comfortable having other people depend on me.

16. I worry that others don't value me as much as I value them.
17. People are never there when you need them.
18. My desire to merge completely sometimes scares people away.
19. It is very important to me to feel self-sufficient.
20. I am nervous when anyone gets too close to me.
21. I often worry that romantic partners won't want to stay with me.
22. I prefer not to have other people depend on me.
23. I worry about being abandoned.
24. I am somewhat uncomfortable being close to others.
25. I find that others are reluctant to get as close as I would like.
26. I prefer not to depend on others.
27. I know that others will be there when I need them.
28. I worry about having others not accept me.
29. People often want me to be closer than I feel comfortable being.
30. I find it relatively easy to get close to others.

Appendix 11: Narcissistic Personality Inventory – 16

Read each pair of statements below and place an "X" by the one that comes closest to describing your feelings and beliefs about yourself. You may feel that neither statement describes you well, but pick the one that comes closest. **Please complete all pairs**.

1. ___ I really like to be the center of attention

   ___ It makes me uncomfortable to be the center of attention

2. ___ I am no better or no worse than most people

   ___ I think I am a special person

3. ___ Everybody likes to hear my stories

   ___ Sometimes I tell good stories

4. ___ I usually get the respect that I deserve

   ___ I insist upon getting the respect that is due me

5. ___ I don't mind following orders

   ___ I like having authority over people

6. ___ I am going to be a great person

   ___ I hope I am going to be successful

7. ___ People sometimes believe what I tell them

   ___ I can make anybody believe anything I want them to

8. ___ I expect a great deal from other people

   ___ I like to do things for other people

9. ___ I like to be the center of attention

   ___ I prefer to blend in with the crowd

10. ___ I am much like everybody else

___ I am an extraordinary person

11. ___ I always know what I am doing

___ Sometimes I am not sure of what I am doing

12. ___ I don't like it when I find myself manipulating people

___ I find it easy to manipulate people

13. ___ Being an authority doesn't mean that much to me

___ People always seem to recognize my authority

14. ___ I know that I am good because everybody keeps telling me so

___ When people compliment me I sometimes get embarrassed

15. ___ I try not to be a show off

___ I am apt to show off if I get the chance

16. ___ I am more capable than other people

___ There is a lot that I can learn from other people

Appendix 12: The Assessment of Sadistic Personality (ASP)

Assessment of Sadistic Personality (ASP; Plouffe, Saklofske & Smith, 2017

Please read each of the following statements and rate the extent you agree or disagree. Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1----------2----------3----------4----------5

Strongly disagree **Strongly Agree**

1. I have made fun of people so that they know I am in control.
2. People do what I want them to because they are afraid of me.
3. When I tell people what to do, they know to do it.
4. I never get tired of pushing people around.
5. I would hurt somebody if it meant that I would be in control.
6. I control my friends through intimidation.
7. When I mock someone, it is funny to see them get upset.
8. Being mean to others can be exciting. (Pleasure-seeking)
9. When I get annoyed, tormenting people makes me feel better.
10. I have hurt people close to me for enjoyment.
11. I enjoy humiliating others. (Pleasure-seeking)
12. I get pleasure from mocking people in front of their friends.
13. I think about harassing others for enjoyment
14. I have cheated others because I enjoy it.

15. I think about hurting people who irritate me.

16. I'd lie to someone to make them upset.

17. I have stolen from others without regard for the consequences.

18.Making people feel bad about themselves makes me feel good.

19. I am quick to humiliate others.

20. I have tormented others without feeling remorse.

Appendix 13: The Severe Sexual Sadism Scale (SESAS)

Items in the Severe Sexual Sadism Scale (SESAS; Nitschke, Osterheider, & Mokros, 2009)
1. Offender is sexually aroused by sadistic acts
2. Offender exercises power/control/domination over victim
3. Offender humiliates or degrades the victim
4. Offender tortures victim or engages in acts of cruelty on victim
5. Offender mutilates sexual parts of victim's body
6. Offender engages in gratuitous violence or wounding toward victim
7. Offender keeps records (other than trophies) or trophies (e.g., hair, underwear, ID)
8. Offender mutilates nonsexual parts of victim's body
9. Victim is abducted or confined
10. Evidence of ritualism in offense
11. Insertion of object into bodily orifices

Appendix 14: Interview Schedule

Sexual sadism and trauma in psychopathy

Topic guide

Version 1.1

10/11/2018.

Thank you very much for agreeing to meet with me today. I am going to ask you a few questions about three different topics.

First, can I check whether you have signed and returned the consent form?

OK, let's start with the questions.

PART 1: "Early relationship with caregivers"

In this, the first part of the interview, we are going to discuss your relationship with your parents/caregivers and your early childhood experiences.

1) Can you tell me a bit about your relationship with your parents duringyour early childhood?
2) To what extend do you think your parents took care of your needs as a child?
    - Prompt [if positive]:how did your mother show concern and seem to care for you, when you were a child?
    - Prompt [if negative]: how did your mother respond to you when you were worried or upset?

3) To what extent did your mother make you feel loved and accepted when you were a child?
    - Prompt [if positive]:how often did she express her affection towards you?
    - Prompt [if negative]:how did your mother make you feel unloved as a child?
4) How would you describe your relationship with your father in your early childhood?
    - Prompt [if positive]:how did your father express his affection and tenderness towards you?
    - Prompt [if negative]:how often did your father become aggressive towards you?
5) When you had problems or felt worried as a child, could you rely on anybody around you to make you feel better and/or safe?
    - Prompt [if positive]:how did this person support you?
    - Prompt [if negative]: how did you cope with difficult feelings and problems?

<u>PART 2: "Aggression and sadism"</u>

OK, thank you for this information. I will now ask you a few questions about aggression and violence.

1) How often do you experiencethe need to be aggressive?
    - Prompt [if positive]:does violent behaviour help you to calm down?

- Prompt [if negative]:when do you feel the need to be aggressive?

2) How do you feel when you become violent?
3) When you feel angry with someone, what do you imagine doing to them?
4) How often do you have violent thoughts?
    - Prompt [if positive]:can you tell me a bit more about the contentofthese thoughts?
    - Prompt[if negative]:what do you think triggers these violent thoughts?

PART 3: "Victim selection criteria"

Thank you once again for this information. Let's move now to the third and final part of our conversation, where I will ask you a few questions about how you chose your victims.

1) Can you tell me a bit about how you chose your victims?
    - Prompt: did you choose your victims randomly or was the selection based on specific criteria?
2) How did you feel during the offence?
3) What did the victim represent to you?